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Permit or Prohibit

An enquiry into the morality of illegal drugs
and into their legalisation and decriminalisation

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Abstract of Thesis

Permit or Prohibit; Legalisation and Decriminalisation?

The aims of this research project were firstly to examine the morality of taking psychoactive drugs for recreational purposes and secondly to explore the case for and against legalisation and decriminalisation.

The thesis begins with a description of these drugs: what they are, how they work, their usage, addiction, harm and death rates. A brief account follows of their historical background, and how the policy of prohibition came to be implemented.

Next the morality of illegal drug use is explored. For this the methodological approach of ethical analysis of the normative philosophies is used, namely relativism, Kant's deontology, consequentialism and virtue ethics. Included here was an assessment of the views of the public on the matter.

Research of documentary evidence showed that some European countries had better drug policy outcomes than most. These countries were Portugal, the Netherlands, Germany, Switzerland and the Czech Republic and further methodological research revealed the reasons for these good outcomes. These procedures are described and analysed.

The outcome of the research led to the conclusion that it is morally acceptable to use such drugs, *up to a point*. Moral obligations are incurred not only by the user, but also by their neighbour and by the State.

The question why some countries had good drug policy outcomes was because all had developed a measure of legalisation and decriminalisation, covertly rather than openly, for the official international drug policy is still prohibition. Furthermore they had understood the existence of risk and the need for harm reduction and had undertaken measures to deal with them.

The final part of the project is to undertake a synthesis of these countries' best practice and formulate a future model drug policy for the United Kingdom.

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Preface

After retirement from Public Health Medicine, I undertook work in Disability Assessment as a Medical Advisor to the Department of Work and Pensions. Here I saw many claimants for benefits who were active or recovered drug addicts. Some were suffering mental illnesses or physical problems such as AIDS, hepatitis B and C, ulcerated legs and thrombosed veins, in some cases so severely affected as to be wheel chair bound. Many relied upon criminality or prostitution to pay for their addiction. Most seemed to want to come off their addiction yet were craving for the next fix. Many had neglected seeking medical help or had left it too late, for fear of the police and the punishments which might await them. I heard some harrowing stories.

It was clear that these people had no difficulty talking to me. Maybe they realised that I was not a General Practitioner but with my Public Health Medicine background may have sensed, that one of our roles is to act as an advocate for the public, especially for the medically disadvantaged or disenfranchised.

It was obvious to me that drug addiction was an illness and certainly not a matter of moral judgment. If street drugs were pure and the means of taking them clean and safe, many of the consequences which I saw before me could have been avoided. Furthermore if they could be legally available and licensed (like an alcohol off-licence shop) then prostitution and stealing might become unnecessary and the criminalisation of so many young people might be avoidable.

Looking at the problem with the eye of a consultant in Public Health Medicine, it seemed to me, that this really was a matter for Public Health to undertake. It could not be solved by applying legal sanctions to *people who are not criminals but are victims and in need of medical care*. It appeared to be self evident that the drug addict's only crime was *weakness* to have succumbed to the lure of drugs; that did not seem to me to be a valid basis for branding them a criminal, an outcast, unemployable as the person sitting before me was.

If there are criminals about they are the people who have exploited the person's fallibility, and the law seemed inappropriate as it is. Indeed if drugs were legalised there would be no need for the law at all.

Of course taking drugs with the potential for causing addiction is unwise, it is risky, and it is better not to start. That is not a crime, though, any more than other risky activities; football, skiing, motor-car racing, steeple-chase riding for example. People have a right to do what they want with their own bodies especially if they are young and take risks and want to have adventures; as we all did once. The State has no right to interfere in that, and most people are not harmed as a result. Not unless an injury is incurred, or the adventurer gets lost in the jungle, or gets into trouble sailing the Atlantic.

It is the same with illegal drug taking, drinking and smoking. People get pleasure from them and think the risk is worth while. It is up to Public Health to educate, especially the young, to point out the risks and advise harm reduction: wear a seat belt if you are in a car, a crash helmet if on a bicycle or a horse, don't drink if you are going to drive and so on. Drink and smoke socially in moderation. Think if you are going to take recreational drugs, and seek help if you cannot stop. Health promotion, risk reduction and harm prevention and care must be the answer.

This raises many ethical questions: is the taking of drugs a moral matter or not? And would it be better if the drug scene was decriminalised and the acquisition of drugs legalised? Would the whole matter be better out of the hands of the police and passed to Public Health Physicians to deal with?

That might not prove popular with villains, gangsters, policemen, lawyers, judges and prison warders who might find their livelihood under threat!

Now, having taken the diploma course in the Philosophy and Ethics of Medicine and Health Care of the Society of Apothecaries, I feel I might, with the help of my tutors at the UEA, be somewhat better equipped to look into these problems and come to some conclusions.

This research is dedicated to those Members of Parliament who spoke out so strongly on the subject on 30th October 2014. I will present it to who ever goes from the UK to the UN Special Session on Drugs in 2016, and hope it might be of some value to them.

Chapter 1. Introduction and Background

The subject will be introduced firstly by defining the scope and definitions of the drugs which are to be considered. Next the historical background will be covered briefly where this is relevant to the changing morality of drugs of addiction.

Finally there will a comment on some problems of drug classification in the UK.

Drugs of addiction are by definition ‘psychoactive’* that is they act on the brain in a mood altering manner. The World Health Organisation defines them as drugs where the:

Repeated use of a psychoactive substance or substances, to the extent that the user (referred to as an addict) is periodically or chronically intoxicated, shows a compulsion to take the preferred substance (or substances), has great difficulty in voluntarily ceasing or modifying substance use, and exhibits determination to obtain psychoactive substances by almost any means.¹

The Mayo Clinic in Rochester, Minnesota, has as its definition:

Drug addiction is a dependence on an illegal drug or a medication. When you're addicted, you may not be able to control your drug use and you may continue using the drug despite the harm it causes. Drug addiction can cause an intense craving for the drug. You may want to quit, but most people find they can't do it on their own.

For many people, what starts as casual use leads to drug addiction. Drug addiction can cause serious, long-term consequences, including problems with physical and mental health, relationships, employment and the law.

You may need help from your doctor, family, friends, support groups or an organized treatment program to overcome your drug addiction and stay drug-free².

The two definitions differ in that the first is descriptive; the second implies there may be consequences from drug taking and the need to do something about them. It goes on to hint at the part medical support may play in helping an addict in their illness.

1.1 The aetiology of the use of drugs of addiction.

There are two elements in the causes for the use of psychoactive drugs and the addiction to them. The one is the action on the brain and the second the circumstances of the user.

The neuroscientific explanation,³ is that the brain is believed to have ‘reward centres’, located in the prefrontal and cingulate cortex, which if stimulated give the person the feelings of happiness, satisfaction and peace. Impulses through the senses: eyes, smell, taste, etc from pleasurable situations, initiate brain activity causing neural or humoral

*What will be discussed here are psychoactive, that is ‘mind altering’, drugs (often referred to in the USA as narcotics) which are used for recreational purposes and are generally deemed, in Western countries, to be illegal. Psychoactive substances which are legal (caffeine as in tea or coffee and nicotine in tobacco) will be discussed briefly, though they will, at times, be referred to. Medicinal drugs, which have psychoactive properties, are referred to as ‘psychotropic drugs’ (for they move the psyche), and may cause addiction, are also not included. Nor are illegal drugs, which are not psychoactive, such as cortisone related substances, used to improve athletic performance. Abuse of substances such as solvents and other inhalants will also not be discussed.

¹ WHO Lexicon of Drugs of Addiction
www.who.int/substance_abuse/terminology/who_lexicon/en/

² Mayo Clinic Web-site for general information
www.mayoclinic.org/diseases-conditions/drug-addiction/basics/definition/con-20020970

³ Wikipedia Reward system. en.wikipedia.org/wiki/Reward_system

stimulation of the reward centres which once activated generate, through connections to other parts of the brain, the feelings of happiness.

Some people are believed to have impaired pathways to the reward centres or a diminution of sensitivity to the stimulation. In either event the centres are underactive and a person does not feel as much happiness as they might. This deficiency might be the result of trauma, illness or might have a genetic basis.

Such people will respond to the drug in compensating for their inherent deficiency and enjoying the happiness they had hitherto been missing. If they are not able to satisfy that absence, they feel a craving for the drug, and that, if severe, leads to addiction, in that the drug becomes essential to make up for the absence of reward stimulation.

Other people will not have impaired reward centre function; in them the action of a psychoactive drug is to heighten the pleasure they would feel. Thus 'happiness' may be experienced as 'ecstasy'; colours may appear brighter and exotic and so on. The environmental circumstances of the user also play a large part in whether a person takes drugs in the first place and whether they remain a casual user or become addicted. These matters are of the greatest importance in the prevention of drug misuse and treatment of the addict and will be discussed in detail later.⁴

Family background is significant: if the parents are users that will influence their children. Social circles are relevant, where a young person lacks confidence or wants to conform with the drug taking habits of their elders or peers ⁵&⁶.

Poverty plays an important part; a deprived person may have little to enjoy and turns to drugs to compensate, finding solace and escape from life's drabness in drug related dreams. Unemployment is a factor, for people who have who have nothing to do all day occupy their time with drugs, alcohol and smoking. Stevens⁷ makes the case that social inequality and poverty are the most important factors for the reasons why people take to drugs and stay with them. He points out that programmes to eradicate the use of drugs will fail if this is not taken into account.(a)

Stress makes a person need to relax and the use of a 'spliff' occasionally may become a necessity and addiction. There may be occupational needs to use drugs: film stars may need to boost their performance and then may need further drugs to relax and sleep and well-known politicians have been addicts.⁸ Wartime air-force pilots used drugs⁹ to keep alert, A person with psychological or personality problems may be disposed to compensate for them with drugs; or indeed the use of drugs may give rise to such illnesses, or uncover the proclivity for them.

⁴ DWP Research Project No 640

www.gov.uk/.../problem-drug-users-experiences-of-employment

Which gives a very comprehensive profile of Problematic Drug Users and the measures needed to provide care and treatment for them

⁵ Bauld L et al (2010) *Problematic Drug Users' Experiences of Employment and the Benefit System*

⁶ Kaplan B, Stevens S and Robbins C (1984) *Pathways to Adolescent Drug Use: Peer Influence, Self-Derogation Weakening of Social Controls, and Early Substance Use.* ,Journal Health and Social Behaviour Vol.25,No3 pp 270-289

⁷ Stevens A (2011) *Drugs, Crime and Public Health, the political economy of drug policy* Routledge, Oxford. He deals with this comprehensively in Chapter 2: *Afflictions of inequality, the social distribution of drug use, dependence and related harms*

⁸ Rennell T (2013) *New book reveals how Marilyn Monroe, President Kennedy and Elizabeth Taylor were drug addicts.*

www.dailymail.co.uk/.../New-book-reveals-Marilyn-Monroe-JFK-Liz-Taylor.

(a) see Stevens A (2011) at Annex A where a summary of his views are given

⁹ Cornum R, Caldwell J, Cornum K (1991) *Stimulant Use in Extended Flight Operations* (in the Gulf War) www.airpower.maxwell.af.mil/airchronicles/apj/apj97/.../cornum.html

In short a person takes to drugs of misuse for a multifaceted mix of psychological, social, environmental and physical reasons¹⁰. Not all people using drugs become addicted and the majority do not.

1.2 Classification of Psychoactive Drugs

There are three different taxonomies each of which is relevant: classification by use, by their pharmacological effects and by their legal implications.

1.2.1 Usage of Psychoactive Drugs

Medicinal use as anaesthetics, anxiolytics, analgesics, and in the treatment of epilepsy. Spiritual and Ritualistic use in some religious cults. The 'whirling dervishes' are said to be intoxicated with hashish, and the Peyote Native Americans use a mescaline substance, for which they have a Government dispensation to use, despite the fact that it is classified as a dangerous drug of addiction. A striking example of the use of psilocybin ('magic mushrooms') in 1962¹¹ was the so-called 'Good Friday' experiment.(b)

Socially acceptable use. These are the mild stimulants: nicotine in tobacco, caffeine in tea and coffee, alcohol, khat,¹²(c)(the leaf form chewed in much of Africa and South America), betel nut chewed in India, Myanmar and throughout Southern Asia. These will not be discussed further though they may from time to time be referred to.

Recreational drugs, used because people enjoy their effects, may use them as antidepressants, for solace or when anxious. They are the subject matter of this dissertation, and will be discussed next.

1.3 Recreational Drugs

They are classified by their effects.¹³

Benzodiazepines: diazepam, temazepam, lorazepam, prazepam, oxazepam (known as: *benzos, bzd's, downers, and heavenly blues*).

These are sedatives, hypnotics, anticonvulsants and muscle relaxants. Are used as anxiolytics, for insomnia, agitation and may cause aggression. Tolerance is common, and potentiation with alcohol is dangerous. Used orally or if intravenously they may transfer infectious diseases, cause abscesses,

Cannabis: from herb or artificial cannabinoids, including natural cannabis fortified with THC (Tetrahydrocannabinol). (known as *spliff, hash, grass, weed, marijuana, and some fifty other synonyms*. Cannabis fortified with THC is known as *spice, or skunk*)

These cause euphoria, anxiety and hallucinations. In a 'high' the user may experience alteration of perception and a feeling of relaxation and well-being. Enjoyment is increased

(b) see Annex A (b) for a description of the very long acting effects of psilocybin

(c) see Annex A (c) for Rifkind's further views on khat

¹⁰ Fieser J (2014) *The Practice of Morality: Drugs* Ch 3-5 the arguments for and against legalisation
<https://www.utm.edu/staff/jfieser/class/300/3-drugs.htm>

¹¹ Koppleman A (2006) *Drug Policy and the Liberal Self*. Northwestern University Law Review. 2006
<https://litigation-essentials.lexisnexis.com/.../app?Rev p288 footnote 44>

¹² Rifkind H 2014. *The Spectator* 28 June 2014 wrote: 'I may not know much about khat, but I know banning it is crazy'.

¹³ Department of Health (2011) *A summary of the health harms of drugs Technical*

Document www.nta.nhs.uk/uploads/healthharmstechnicalfinal-v12.pdf Most of the facts in this section have been taken from this document.

as is the appreciation of humour, music and increased libido. In a 'low' the user, having a 'bad trip' may feel despair.

No deaths have been reported from cannabis when used alone.¹⁴ Deaths may result from cannabis taken as cocktails with other psychoactives. Intoxication impairs driving and handling of dangerous machinery(y)

Dissociatives: Ketamine, phencyclidine, dextrometorpham.(known as *pap*, *DXM*.)

These are hallucinogens, give rise to feelings of detachment from the body and the world. Induce dream like states, and unawareness of the body.

Overdose may cause respiratory and circulatory depression. Minor symptoms are anxiety, shaking and palpitations.

Hallucinogens:(also known as psychedelics, dissociatives and delirients),LSD¹⁵, mescaline, peyote, and psilocybin (magic mushrooms). (known as *acid*, *blotter*, *cid*, *sunshine doses*, *golden dragon*, *heavenly blue*, *loony tour*, *pane*, *Purple Heart*, *yellow sunshine*, *superman*)

They cause entheogenic states and psychonautics;a person experiences exaggeration of perception of colours, objects, colours and size; they may enter a trance state, meditation, and dreams. There may be feeling of divination and of the gift of healing. They may feel invincible, able to fly and want to jump off buildings to do so. Aldous Huxley¹⁶ explored the effects of mescaline, and Timothy Leary the effects of LSD and psilocybin.

Empathogens:MDA(3.4.methylene-dioxy-amphetamine)MDMA;(methylene-dioxy-methamphetamine),mephedrone.(known as *Ecstasy*, *Meow-Meow*)¹⁷

They produce feelings of love, emotion, serenity, psychedelic states, are anxiolytics, stimulants and antidepressants.

Opiates: opium, morphine, diamorphine (heroin).

May cause euphoria, feeling of safety. In small doses euphoria and stimulation. Used in pain relief (causes forgetfulness) and sleep. When a person is addicted it may cause hyperactivity, or under activity, depressed mood, apathy and lack of motivation.

Stimulants: amphetamine, caffeine, ephedrine, MDMA, Dexedrine, methylamphetamine,(Pervitin)^(dd) mephedrone, nicotine, cocaine*. These cause alertness, wakefulness, endurance, increased productivity, and motivation as well as hyperactivity. Cocaine especially generates feeling of confidence,alertness and happiness.

Overuse can cause psychotic episodes, social detachment.

(y) see Annex A for a detailed account of cannabis.

(dd) see Annex A for an account of this drug which is much used in the Czech Republic

¹⁴ Ashton CH (2001) *Pharmacology and effects of cannabis: a brief review* (British Journal Psychiatry) bjp.rcpsych.org/content/178/2/101.full

¹⁵ Roberts A (2012) *Albion Dreaming* Marshall Cavendish,London (Norwich City Library) at page 230 quotes a BBC broadcast of 1973 in which it was claimed that over 600,000 people had taken LSD and there had been no fatalities

¹⁶Huxley A 1954 *Doors of Perception*, Chatto and Windus ; for a detailed account of Mescaline usage (Norwich City Library)

¹⁷ Weil A. 1998 "MDA *The Love Drug*". *The Marriage of the Sun and Moon*. Houghton Mifflin Co. 1998. (Norwich City Library) this gives a full account of the author's experiences in using Ecstasy

* Cocaine and Crack come from the Coca leaf which is chewed by indigenous South Americans. Cocaine, which is 'snorted', that is inhaled nasally, is the powdered form of the drug and crack, which is smoked, is solid. The smoked cocaine has the quicker action and better 'high'. It is said that both have a slow 'let down' which can be very long lasting.Cocaine costs £42 per gram(one dose) and crack £10-£20 per 0.2 gram (one smoke).

from *Drugscope* www.drugscope.org.uk/resources/drugsearch/drugsearchpages/cocaineandcrack.

1.4 Legal Classification of Drugs of Addiction

Drugs of addiction are also classified according to the penalties they attract for users and traffickers

Grade	Drug	Possession	Production and Supply
A	Crack cocaine, cocaine, ecstasy (MDMA), heroin, LSD, magic mushrooms, methadone, methamphetamine (crystal meth)	Up to 7 years in prison, an unlimited fine or both	Up to life in prison, an unlimited fine or both
B	Amphetamines, barbiturates, cannabis, codeine, methylphenidate (Ritalin), synthetic cannabinoids, synthetic cathinones (eg mephedrone, methoxetamine)	Up to 5 years in prison, an unlimited fine or both	Up to 14 years in prison, an unlimited fine or both
C	benzodiazepines (diazepam), gamma hydroxybutyrate (GHB), gamma-butyrolactone (GBL), ketamine, piperazines (BZP)	Up to 2 years in prison, an unlimited fine or both (except anabolic steroids – it is not an offence to possess them for personal use)	Up to 14 years in prison, an unlimited fine or both
D Temporary class	NBOMe and Benzofuran compounds	None, but police can take away a suspected temporary class drug	Up to 14 years in prison, an unlimited fine or both

Table 1 Legal Classification

Source *Misuse of Drugs Act 1971*¹⁸

Newly introduced drugs of addiction, known as ‘legal highs’ (also known as Novel, or New Psychoactive Substances, NPS) which have not yet been assessed are placed in a temporary Class D.

The system of classifying as shown above has come in for much criticism, for some of those drugs shown as Class A are by no means the most dangerous: magic mushroom (mescaline), ecstasy and LSD causes little harm to the user and should logically be in Class C, as should cannabis.¹⁹ An alternative and more logical system was proposed in 2007 by

¹⁸ Misuse of Drugs Act 1971

www.legislation.gov.uk/ukpga/1971/38/pdfs/ukpga_19710038_en.pdf

¹⁹ Independent Inquiry into the Misuse of Drugs Act 1971 (‘The Runciman Report’ p4 para17 recommended that Ecstasy, and LSD should be placed in Grade B and cannabis in Grade C)

Nutt et al²⁰ and comment is made on that below in the paragraph on Harm. The All Party Parliamentary Group for Drug Policy Reform recommended an independent drug Classification body²¹, which would classify drugs according to the level of risk identified on a scientific basis.

1.5 Symptomatology of recreational drugs

All recreational drugs are taken because they generate a feeling of pleasure, and the quickest way of achieving that is by intravenous use, for that rapidly achieves the ‘rush’, the sudden feeling of well-being. Then come the prolonged feelings, as described above, different for the various drugs, the so-called ‘high’, which lasts for differing periods. All drugs have a ‘half-life’, that is at a certain point after administration their effects start to diminish, due to detoxification within the body and elimination of it. The lack of the drug causes ‘withdrawal symptoms’, characteristically a feeling of anxiety, misery, with palpitations, trembling, sweating, and diarrhoea.

Once the effect the drug on the brain has worn off, the feelings of deprivation arises with the desire for more. This is the characteristic craving for another dose. Another effect is that the brain centres may acquire a degree of tolerance to the drug, so that a larger dose is needed to generate the same result as before; though not all people are equally subject to these effects of dependence.

The sensations of craving and withdrawal are partly psychological and partly physiological, and that is made use of in detoxification programmes, in that the patient may be tricked into believing they are receiving a replacement substance of the same strength as the original drug of abuse, when in reality they are not.

If smoking is your addiction of choice, it is easy to take another cigarette out of the packet. However if heroin for intravenous use is required that is more difficult to acquire, and pay for with the resultant addiction often leading to crime(d). Such drugs of addiction are also the ideal product to be sold by street traffickers. The customer will always return for a resupply and indeed will want more and more. They will never be satisfied because it is very difficult to cease being addicted.

²⁰ Nutt, D, King, L, Saulsbury, W, and Blakemore, C. (2007) *Development of a rational scale to assess the harm of drugs of potential misuse*. *Lancet*. 2007; 369: 1047–1053

²⁰ All Party Parliamentary Group for Drug Policy Reform (2013)
www.drugpolicyreform.net/

(d) see Annex A for details of how thieving is carried out.

1.6 Drug usage rates

The European Monitoring Centre for Drugs and Drug Addiction report for 2013²² shows at Table 2 the usage of common psychoactives in the UK whole of Europe.

	Cannabis	Cocaine	Amphetamines	Ecstasy	LSD
UK adults aged 15-64 in 2006 as % of population who have taken drugs					
Life-time	30.2	7.7	11.9	7.5	5.6
Last 12 months	8.4	2.7	1.4	1.9	0.2
Last 30 days	4.9	1.3	0.5	0.9	0.1

UK youths aged 16-24 in 2006 as % of population					
Last 30 days	7.3	0.3	0.6	0.1	0.0

Whole of Europe adults aged 15-64 in 2006 as % of population					
Life-time	22	3.6	3.3	2.8	nk
Last 12 months	7.1	1.2	0.6	0.8	nk
Last 30 days	3.7	0.6	<0.3	>0.3	nk

Table 2 Drug Usage 2006

Courtesy EMCDDA Report

This table shows cannabis to be the most widely used of the psychoactives, especially amongst young people. It is also noteworthy that *drug usage is significantly higher in the UK than in Europe as a whole.*

Additional noteworthy facts were that problem usage of opiates for European adults was 0.1- 0.6% of the population. Of all European adult deaths 3.5% were attributed to drug usage, and 70% of those were the result of opiate use, as shown in Table 3.

Used cannabis in last 30 days		Of that 4.1% cannabis users, the % users were:			
		1-3 times	4-9 times	10-19 times	20-30 times
15-64 age group	4.1% of all adults	67.9%	11.3%	9.1%	11.7%
15-64 age group	0.5% of all adults were daily users				
15-30 age group	0.7% of all younger adults were daily users				

Table GPS-10

Table 3 Frequent users of cannabis

Courtesy European Centre for Drugs and Drug Addiction

The daily usage rate of cannabis smoking does *not* indicate the addiction rate, for that implies, as stated in the definition above, that the addicted user is unable, without difficulty, to cease the habit. However it does illustrate the habit of the frequent user as shown in the following table:

The numbers of people using psychoactives in the UK show a preponderance of 'legal' rather than 'illegal' drugs as shown in the next diagram.

²²EMCDDA Reports *European Drug Report 2013*

www.emcdda.europa.eu > News and events > Events > Events pages

Figure 1. Percentage of adults reporting substance use, 2009

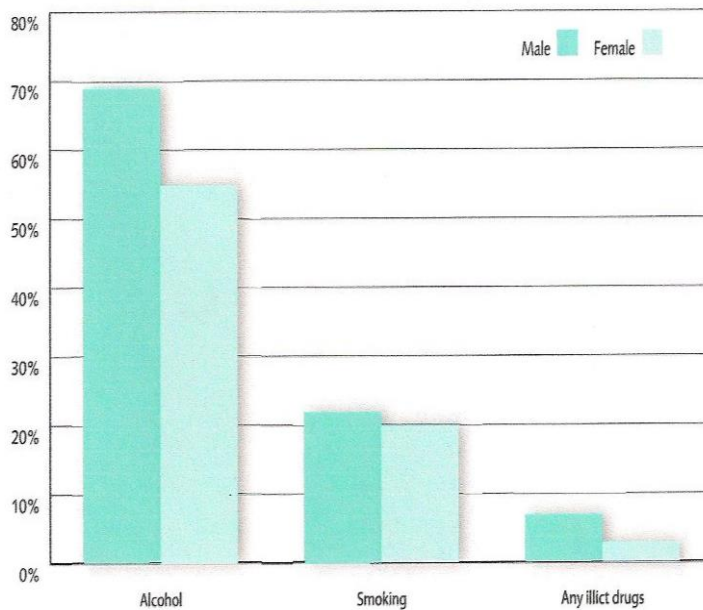
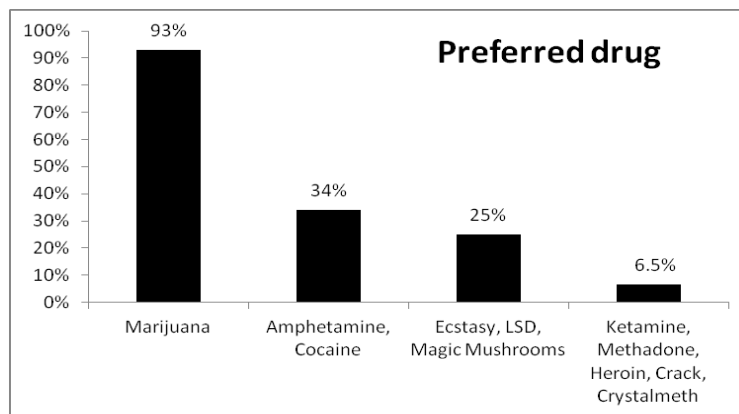


Table 4 Adults using psychoactives
source General Lifestyle Survey ,Office for National Statistics

Among 32.2 million adults aged 16 to 59 in England and Wales there are 20 million weekly alcohol drinkers, 6.8 million smokers and 1.6million regular users of illicit drugs²³

The British Drug Survey (2014)²⁴ showed that in the whole population of the UK 31% have taken drugs, and of those 21% still do.



Of drug takers, 13% have had a problem (2 million people) of which half say they had overcome it. The preferred drugs when are given as on the Table 5

Table 5 Drug Use Preferences
Source British Drug Survey 2014

Most of the reasons for starting to take drugs might be put down to social circumstances as shown in Table 6

²³ Office for National Statistics(2009)

²⁴ Mann J (2014) *British Drug Survey 2014* Guardian Newspaper 5 October 2014
www.theguardian.com>Society>drugs

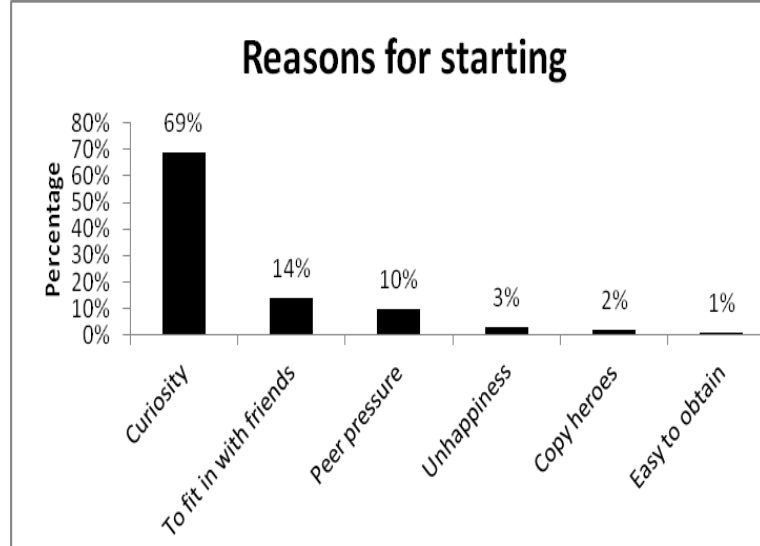


Table 6 Reason for Starting Drugs
Source British Drug Survey 2014

1.7 Addiction rates for psychoactive drugs

All psychoactive drugs may be addictive. It is one of the factors contributing to the harm which may be caused. Not all users suffer harm; many addicts may lead a normal life and others undergoing detoxification return to work and normal family life on prescription doses of heroin or methadone. However others may suffer deteriorating health and withdrawal from society; the user's family suffers too because of the effects that has. Then there is the need to acquire sufficient money to pay for the habit, which will have become more difficult when the user becomes unable to work or is dismissed from it. There are many moral problems which will be examined in Chapter 2, and concern the person who is not yet addicted, but should be alert to the fact that they might become so, and also the confirmed addict and their moral duty to do something about it.

The following table shows the relative consistency of addiction over the years.

Kleiman (2006) ²⁵		Lopez-Quintero et al ²⁶ (2011)	
Addiction rates of casual users		User transition to addiction	
Cigarette smokers	59%	Cigarette smokers	67.5%
Cocaine users	22%	Cocaine users	20.9%
Alcohol drinkers	17.1%	Alcohol drinkers	22.7%
Marijuana users	13.1%	Marijuana users	8.9%
Heroin users	Not given	Heroin users	Not given

Table 7 Addiction Rates

It was not explained why neither authority showed the addiction rates for heroin.

²⁵Kleiman M A R (1992) quoted in Koppleman A (2006) *Drug Policy and the Liberal Self* School of Law and Political Science, North Western University

²⁶Lopez-Quintero C et al(2011) *Probability and predictors of transition from first use to dependence on nicotine, alcohol, cannabis, and cocaine: results of the National Epidemiologic Survey on Alcohol and Related Conditions Drug Alcohol Depend.* 2011 May 1;115(1-2):120- .ncbi.nlm.nih.gov > NCBI > Literature > PubMed Central (PMC)

1.8 Harm caused.

When the harm caused by psychoactive recreational drugs is considered, it is to be remembered that the harm caused by drugs *acceptable* to society is much greater. Tobacco related illnesses cause 40% of all hospital admissions, and alcohol related accidents result in 50% of all A&E attendances.²⁷

All drugs of abuse can cause three different types of harm. They may result in *physical* and/or *mental harm* to the user; may induce *dependence* and may have *effects upon the user's family, community and society*.²⁸ An expression of harm so measured is shown in Table 8

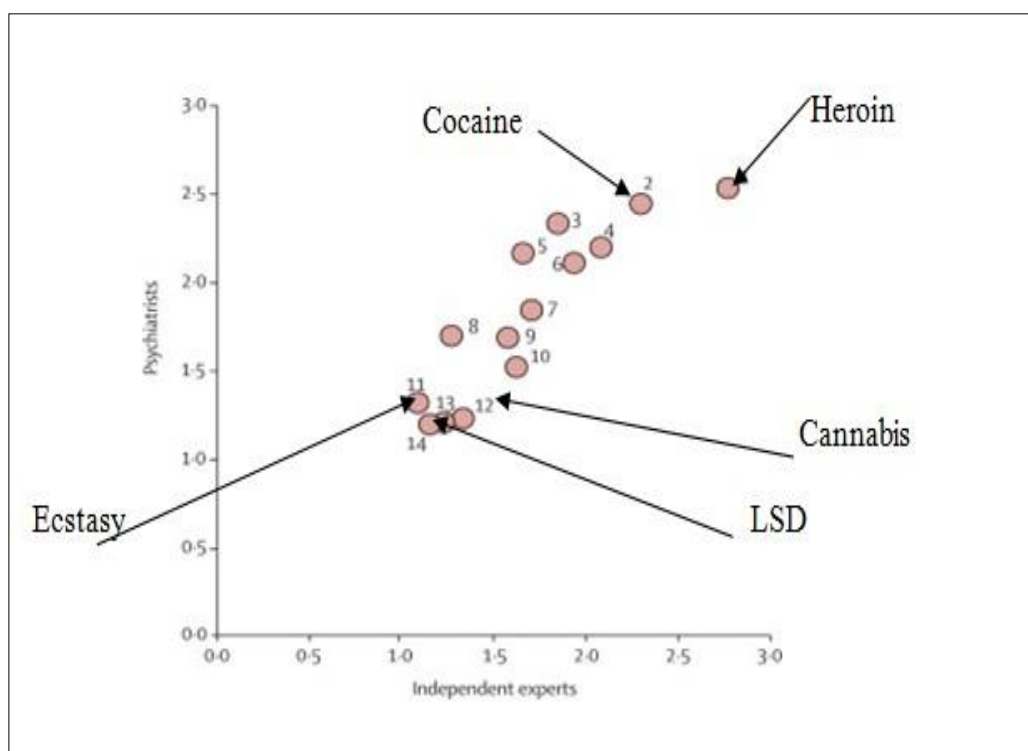


Table 8 Psychoactive Drugs and harm

Courtesy of The Lancet 2007 Nutt et al²⁹

Guide to numbers on diagram

1 Heroin	5 Amphetamine	9 Buprenorphine	13 LSD
2 Cocaine	6 Methadone	10 Tobacco	14 Steroids
3 Alcohol	7 Benzodiazapine	11 Ecstasy	
4 Barbiturate	8 Solvents	12 Cannabis	

The substances shown above were listed independently by two panels, the one of psychiatrists specialising in addiction, and the other of experts in drugs of addiction. Each was assessed against all three harms, scored and plotted across the graph. (Not all substances shown are dealt with in this paper)

High in harm value are heroin, cocaine, alcohol, barbiturate, amphetamine and methadone (a heroin substitute used in detoxification but also buyable on the street). Of

²⁷ Nutt et al (2007) *ibid* p1048

²⁸ Nutt, D, King, L, Saulsbury, W, and Blakemore, C. (2007) *Development of a rational scale to assess the harm of drugs of potential misuse. Lancet.* 2007; 369: 1047–1053

²⁹ Nutt et al (2007) *ibid*

lesser harm were Ecstasy, cannabis and LSD. Low also was tobacco which although having a very high addiction risk, has little impact on the community and only harms the user in the long term. Likewise steroids are ranked low, for although the harm to the individual is considerable, the harm to the community is nil.

1.9 Deaths from Psychoactive Drug Use

There are three aspects of medical harm to the user which may result from drug use; acute poisoning, respiratory depression for example from opioids, or cardiac arrest from the use of cocaine, or simple overdose or the use of adulterated substances. Secondly chronic physical harm may occur; for example lung disease from cannabis or tobacco use, mental illnesses may ensue after using many psychoactives, or localised damage to tissues from nasal inhalation of cocaine, or to limbs from injecting drugs of abuse. Finally there are the conditions especially related to intravenous drug use: hepatitis, HIV and septicaemia. All these have been commented on above and next to be assessed are the death risks from drug usage.

There are important problems to be taken into account concerning the accuracy of the available figures, and some of these will now be considered. Drugs are often taken in combinations, for example alcohol with any drugs or cannabis with tobacco. They may potentiate each other, or only the one may be tested for or reported. The secondary long term effects of smoking and drinking may be recorded on the death certificate but the cause may not feature at all.

The following table shows the UK drug-related deaths over two years

Substance	Annual Deaths 1997	Annual Deaths 2000
Alcohol*	4,917	5,635
Tobacco*	120,000	N/A
Amphetamines	50	59
Benzodiazepines	340	162
Cannabis	13	11
Cocaine	39	80
Ecstasy	12	36
Hallucinogens	1	N/A
Heroin/Morphia	445	238
Solvents	80	64
Total excl Alcohol and Tobacco	2,858	2,968

Table 9 Death Rates from Psychoactive Drugs

Source *Lancet* 2007 Nutt *et al*

However it should be noted that suicides and accidental deaths may not be tested for the drugs which might have been the underlying cause. Traffic-accident deaths would be tested for alcohol, but other drugs may be overlooked, if of small dose (but potentiating the alcohol) or if assessed long after death when the drug might have denatured³⁰ It is therefore better to consider mortality figures related to drug usage as indicators rather than as precise facts.

The mode of death from psychoactive drugs is significant for that leads into the arguments made below for legalisation. Of the 1,263 deaths in England in 2011, *accidental death accounted for 78.4%*, suicide for 12.6% and undetermined reasons 8.5%. (Similar

* Nutt points out that Alcohol and Tobacco count for 90% of all deaths from psychoactive drugs (Nutt *et al* 2007)

³⁰ National Addiction Centre. 2003 *Dangerousness of Drugs. A Guide To The Risks And Harms, Associated With Substance Misuse*. January 20003

percentages were found for other parts of the United Kingdom) This implies that it might be the unknown purity and unknown concentration of drugs bought on the street which may be a factor in the accidental death rate.

The attribution of deaths to substances is also noteworthy: opioids accounted for 61.2% of deaths, cocaine 10.4%, cannabis 2.0%, and ecstasy 1.7%³¹.

1.10 Historical Background

Psychoactive drugs have been recorded in different parts of the world since prehistoric times, and this will be briefly described. More important for this discussion are the developments over the last two centuries in Western countries for they illustrate how the perception of morality of the matter is changing.

Perhaps the oldest recorded use of psychoactives substances in that of hashish (marijuana) used as a medicinal and recreational drug in Taiwan in the 10th Millennium BC; it was also noted to have been used in Morocco in 3,000BC³². It is usually acceptably used in Arabic Countries. Tea was first used in China in 2737 BC as a refreshing drink³³. Native Americans chewed peyote leaf containing mescaline as a stimulant in 5,700 BC³⁴ and psilocybin, (magic mushrooms) a hallucinogenic, was known to have been used in Ancient Egypt as was opium³⁵.

Cocaine in the form of chewed coca leaves was used in Peru 8,000 years ago³⁶ and in Thailand betel juice stained teeth have been found in prehistoric skeletons estimated to be 7,500-8,000 years old.³⁷

Religious denominations express opinions on the morality of wine; thus according to Jewish tradition, Noah, upon making landfall in his Ark, planted a vine, and then became drunk³⁸. Other passages in both Old and New Testaments allow that wine may be taken, but in moderation.³⁹ &⁴⁰ In most Christian Confessions it is an integral part of the service of Holy Communion, but in some it is banned altogether, namely by the Quakers and Methodists.

Islam is initially equivocal on the matter, but then comes out strongly against wine.⁴¹ It cannot always have been so for the poem known to all in the west: the Rubaiyyat of the 12th century Islamic poet, mathematician and philosopher Omar Khayyam, extols the virtues of wine.⁴²

Opium was known to the Sumerians in 3400BC⁴³; Hippocrates (c.460 BC), rejecting the magic attributed to it, acknowledged its useful narcotic qualities.⁴⁴

³¹ National Programme of Substance Abuse Annual Report 2011 (St George's Hospital) p8
<http://www.sgul.ac.uk/research/projects/icdp/pdf/np-sad-13th-annual-report-2012.pdf>

³² Merlin M (2003) *Archaeological evidence for the use of psychoactive drugs in the Old World*
Economic Botany 57(3)259-32

³³ Wikipedia *History of tea in China* en.wikipedia.org/wiki/History_of_tea_in_China

³⁴ Wikipedia *Mescaline* en.wikipedia.org/wiki/Mescaline

³⁵ History of Opium, Morphine, and Heroin www.intheknowzone.com/substance-abuse-topics/heroin/history.

³⁶ Palmer J (2010) *BBC News Coca leaves first chewed 8,000 years ago*
www.bbc.co.uk/news/science-environment-11878241 2nd Dec 2010

³⁷ Rooney D F (1993) *Betel Chewing in South East Asia*
rooneyarchive.net/lectures/lec_betel_chewing_in_south-east_asia.ht

³⁸ Genesis Chapter 9 vv 20-21

³⁹ 1 Corinthians Chapter 10 v 31

⁴⁰ John Chapter 2 v 11 *Christ's first miracle describes how, at the wedding at Caana, He turned water into wine*

⁴¹ Holy Qur'an sura 5:90-91 *'intoxicants are abominations of Satan's handiwork, for they turn people away from God and prayer'*

⁴² Rubaiyat of Omar Khayyam (1859 edition) v 11: *'Here with a Loaf of Bread beneath the Bough
A Flask of Wine a Book of Verse - and Thou
Beside me singing in the Wilderness-
And Wilderness is Paradise enow.'*

⁴³ Opium Timeline *A brief history of opium* p1 <http://opioids.com/timeline/index.html>

⁴⁴ Opium Timeline *ibid* p2

Laudanum, a mixture of opium and substances such as treacle was used for many conditions in the middle ages. Thomas Sydenham, the physician famous for many medical advances, introduced 'Sydenham's Laudanum' a mixture of opium, sherry, wine and herbs in 1680⁴⁵ but did not appreciate its psychoactivity.

Twenty years later the Dutch exported Indian opium to China and introduced opium pipe smoking there.⁴⁶ This resulted eventually in the infamous 'Opium Wars,' in which England played a large part.(e)

Opium use in Britain had become popular amongst the intelligentsia, particularly writers, John Keats being a user in 1819⁴⁷. Thomas de Quincy wrote his *Confessions of an English Opium Eater* in 1821⁴⁸; Elizabeth Barrett Browning was writing poetry under its influence in 1837⁴⁹, and 'recreational' use became widespread.

The consequences of drug taking may well be inspiration and pleasure for many: the drug habits of Modigliani, van Gogh, Edvard Munch and Salvador Dali are well documented in their biographies. Then there are Cellini and Michelangelo; and a large number of the Victorian greats including Dickens, Shelly, and Keats. More recently there were the Beatles who even dedicated a song to LSD*: '*Lucy in the Sky with Diamonds*.' Many feel that addiction to drugs has enriched the world. If Berlioz's doctor had succeeded in stopping his addiction, perhaps his genius might have fizzled out, and we might never have had the brilliant, intoxicated inspiration of the *Symphony Fantastique*.⁵⁰

Attitudes however change over time, as will be discussed in Chapter 2. Opium was acceptable during the 19th Century, the 'Time of Enlightenment' as a mood enhancer for intellectuals. Coleridge⁵¹ admitted that he had written his '*Kubla Khan: a Vision in a Dream*' in an opium haze, and a reading of the poem can be understood as the words of a genius with a disordered mind(f) Then he was applauded for his brilliance, now he might have been committed to prison, for by the early 20th Century the attitude of the community had changed and the taking of opiates was considered immoral and should be punished. When Ginsberg⁵² published his poem '*Howl*' written under the influence of mescaline in 1955 it resulted in his publishers and booksellers being arraigned for obscenity (g)

* LSD (Lysergsäure-diethylamid: Lysergic Acid Diethylamide) now a Class A drug is believed not to have caused a single death

⁴⁵Porter R (1997) *The greatest benefit to mankind*. (Fontana Press) p 194. Sydenham declared that: 'among the remedies which it has pleased the Almighty God to give to man to relieve his sufferings, none is so universal and so efficacious as opium'

⁴⁶ Opium Timeline ibid p 3

⁴⁷Hill A (2012) *John Keats was an opium addict, claims a new biography of the great poet..* Guardian Newspaper (21 September 2012) review of new biography by Nicholas Roe. The claim is disputed by the present poet laureate Andrew Motion. www.theguardian.com/Arts/Books/JohnKeats

⁴⁸ De Quincey T *Confessions of an English Opium Eater* '... I do not readily believe that any man having once tasted the divine luxuries of opium will afterwards descend to the gross and mortal enjoyments of alcohol.'

[www.amazon.co.uk/.../Social & Health Issues/Alcohol & Drug Abuse](http://www.amazon.co.uk/.../Social&HealthIssues/Alcohol&DrugAbuse)

⁴⁹Cowell S (2013) *Poetry, pain, and opium in Victorian England: Elizabeth Barrett Browning* www.wondersandmarvels.com/.../poetry-pain-and-opium-in-victorian-england..

(e) see Annex for a short account of the Opium Wars

(f) see Annex A for an extract of the poem.

(g) see Annex A for an extract of the poem

⁵⁰ Jay M (2002) *Opium and the Symphonie Fantastique* mikejay.net/opium-and-the-symphonie-fantastique/

⁵¹ Maher K (2006) *Coleridge's "Kubla Khan": Creation of Genius or Addiction?* www.lurj.org/issues/volume-4-number-1/kubla

⁵² Chartres A (2001) *My Sad Self: Allen Ginsberg's Life* www.english.illinois.edu/maps/poets/g_l/ginsberg/life.htm *An excerpt is at Annex A(h)

Medical use of opium was also general as a cough medicine, teething pain cure, to settle restless babies. In East Anglia tea laced with opium was popular.⁵³ The opium-containing Atkinson&Barker's Royal Infants' Preservative, showed a picture of Queen Victoria and her children on the label of the bottle,^(h) but whether the royal princes and princesses ever actually used it is not known.⁵⁷

At the turn of the century physicians were realising the danger, and for society too, opium had lost much of its attraction. In late Victorian England drug usage was not considered wrong, and opium 'dens' were licensed,⁽ⁱ⁾ though considered distasteful rather as were brothels. Industrialisation in Europe and America led to poverty and squalid living conditions for many of the 'working class'. The reaction was excessive alcohol drinking amongst them. This was considered seriously as an avoidable evil and the Temperance Movement came into being to counter it and the rising drug culture.⁵⁴

The International Opium Convention, signed at The Hague on 23rd January 1912 was followed by a treaty was signed by Germany, United States, France, the United Kingdom and seven other nations. It was directed that:

*'The contracting Powers shall use their best endeavours to control, or to cause to be controlled, all persons manufacturing, importing, selling, distributing, and exporting morphine, cocaine, and their respective salts, as well as the buildings in which these persons carry such an industry or trade.'*⁵⁵

A revised International Opium Convention was signed at Geneva on February 19, 1925, which went into effect on 25th September 1928, in which hemp (cannabis) was included.⁵⁶ However India objected because of the social and religious usage of cannabis in that country and the widespread existence of wild cannabis plants which would make the control of its harvesting and use impossible. Cannabis was excluded therefore from the Treaty.

The 1925 Convention was superseded by the 1961 International Single Convention on Narcotic Drugs.⁵⁷

'This Convention aims to combat drug abuse by coordinated international action. There are two forms of intervention and control that work together. First, it seeks to limit the possession, use, trade in, distribution, import, export, manufacture and production of drugs exclusively to medical and scientific purposes. Second, it combats drug trafficking through international cooperation to deter and discourage drug traffickers'

It was amended in 1971 in adding Ecstasy and LSD and similar drugs, banning substances which could be the precursors of illegal substances and strengthening enforcement through forfeiture of traffickers' assets. All United Nations states, except for ten, signed the convention which required banning the growing, manufacture, transportation, distribution and use of all drugs of addiction, the enforcement of compliance by international monitors.

(h) See Annex A where the label of the bottle of Royal Infants' Preservative is shown.

(i) See Annex A where is revealed how Dr Watson encounters Sherlock Holmes the famous detective.

⁵⁷The Quack Doctor (2010) *Atkinson and Barker's Royal Infants' Preservative*
thequackdoctor.com/index.../atkinson-barkers-royal-infants-preservative

⁵³ Wohl A (1983) *Opium and Infant Mortality*
www.victorianweb.org/science/health/health4.html

⁵⁴ Encyclopedia Britannica (2014) *Temperance movement social history*
www.britannica.com/EBchecked/topic/586530/temperance-movement

⁵⁵ Wikipedia *International Opium Convention 1921*
en.wikipedia.org/wiki/International_Opium_Convention acc 010714

⁵⁶ Wikipedia *International Opium Convention 1925* en.wikipedia.org/wiki/International_Opium_Convention

⁵⁷United Nations *Single Convention on Narcotic Drugs, 1961*
<https://www.unodc.org/unodc/en/treaties/single-convention.html>

This resulted in some countries being unable or unwilling to comply: those whose economies depended upon them as a crop, those where the synthetic manufacture was a major industry, and those, such as Russia and the Eastern Bloc countries which claimed that it would be contra to their constitution to allow in international inspectors.

Article 36 of the Convention required signatories to criminalise

'cultivation, production, manufacture, extraction, preparation, possession, offering, offering for sale, distribution, purchase, sale, delivery on any terms whatsoever, brokerage, dispatch, dispatch in transit, transport, importation and exportation of drugs'

All signatories were also obliged to bring in their own national laws in conformance with the 1961 Convention, and consequently the Misuse of Drugs Act 1971 was enacted by the UK parliament.

1.11 The Misuse of Drugs Act 1971

The Act is based upon the classification of drugs of abuse into Classes A-D. The different classes of drugs attract different penalties for possession or trafficking .

The Act allows the Home Secretary to alter or amend the grading of psychotropic drugs by Order, that is by their own decision and is neither dependent upon changing the Act, nor in taking the advice of the Advisory Council on the Misuse of Drugs.

The placing of drugs in grades thus depends upon historical traditions, advice by the Advisory Council and the whim or political expediency of the Home Secretary, and this naturally gives rise to recurrent anomalies.

Thus *magic mushrooms*, *ecstasy* and *LSD* are placed in Class A, despite the fact that they have a low addiction rate, cause minimal harm and have a virtually non-existent death risk, and logically they should be placed for those reasons in Class C. Similarly in 2008 the Prime Minister, Gordon Brown, decided to upgrade cannabis from Class C to Class B, rejecting the Advisory Group's recommendation saying:

"I believe that if we are sending out a signal particularly to teenagers, and particularly those at the most vulnerable age, young teenagers, that we in any way find cannabis acceptable, given all that we now know about the changes in the way cannabis is being sold in this country, that is not the right thing to do."

⁵⁸

Thereby reversing the advice of the Advisory Council to the previous Prime Minister, Tony Blair, who had agreed to the classification of cannabis in Group C.

Further discord arose in 2009 when the Advisory Council under the chairmanship of Professor John Nutt advised the Home Secretary to downgrade Ecstasy from Class A to Class B. This recommendation was based on a year long study of many thousands of articles which showed conclusively that Ecstasy and LSD were not nearly as dangerous as had been believed, and that riding horses was more dangerous.⁵⁹ Professor Nutt was instructed by the Home Secretary (Jacqui Smith) to change his mind, so when he refused, the Home Secretary dismissed him from his appointment saying:

"I cannot have public confusion between scientific advice and policy and have lost confidence in your ability to advise me as the chair of the Advisory Council" ⁶⁰ & ⁶¹

⁵⁸ Winnett R (2008) *Should cannabis remain a Class C drug?* - DailyTelegraph 1 April 2008

⁵⁹ Stevens A (2011) *Drugs, Crime and Public Health* ibid p78

⁶⁰ Kmietowicz Z (2009). *'Home secretary accused of bullying drugs adviser over comments about ecstasy'*. *BMJ* 338: b61260 Easton M (2009).

⁶¹ *'Nutt gets the sack'*. BBC News 301009

Most of the Advisory Council then resigned too, for they felt they could not continue simply act as spin doctors at the behest of the government.⁶²

Public sentiment may not have been changing but the scientific community's attitudes were. Rolles in the BMJ (2010)⁶³ observed that drug markets can remain in the hands of unregulated criminal profiteers or they can be controlled and regulated by appropriate government authorities. The Chairman of the Bar Council concurred⁶⁴ as did the President of the Royal College of Physicians⁶⁵ and the House of Lords.⁶⁶

The problem undoubtedly was that 'drugs' was a matter politically too hot to handle, at least for the present. Howarth made that clear in his lecture *'Drugs Prohibition or Harm Reduction.'*⁶⁷ In Mid 2014 Parliamentarians visited European and other States who have reduced their countries' drug problems, and the British Press⁶⁸ ⁶⁹ supported this. In October 2014 Parliament debated the subject and there was general agreement that change was essential. This will be discussed in Chapter 2.

1.12 Summary: the Changing Scene of Drug Usage

Psychoactive Drugs have been known in different parts of the world for centuries. But the only ones in common use as a recreational drug have been opium and recently cannabis.

Early in the 20th Century the Temperance Movement initiated the banning of alcohol and drugs, resulting in the International Opium Convention of 1925 in which only three drugs of abuse were banned and the drug prohibition era started.

During the 1960s eighty five addictive drugs were being considered. By 1995 successive amendments had added many more to the banned list. The ever increasing usage of illegal drugs and the steeply rising costs of prohibition led the United Nations to the opinion that Prohibition had failed and that alternative ways should be found to handle the problem of drug usage and harm reduction, implying a measure of acceptance of a changing view of the morality of drug taking.⁷⁰

In 2011 the UN Global Commission on Drug Policy said

*"the global war on drugs has failed, with devastating consequences for individuals and societies around the world"*⁷¹

Another United Nations General Assembly Special Session on Drugs is to take place in 2016.

⁶⁵Brown A (2010) *The Chairman of the Bar Council is right to say we should consider decriminalising drugs* Daily Telegraph 20 July 2010

⁶⁶ BBC News (2010) *Top doctor Sir Ian Gilmore calls for drugs law review* (BBC 17 August 2010)

⁶⁷House of Lords(2013) *Debate 17 October 2013*

<http://www.parliament.uk/pa/ld201314/ldhansard/text/131017-00001.htm>

⁶⁸ Howarth A.(2013) *Drugs Lecture* UEA 28 Nov 13

www.ueapolitics.org/wp-content/uploads/2014/01/Alan-Howarth.pdf

⁶⁹Travis A (2014) *Eleven countries studied, one inescapable conclusion- the drug laws don't work* .Guardian 30th October 2014

⁷⁰ Morris N & Wright O (2014) *Drug Abuse: but is Britain ready to grow up?* Independent 30th October

⁷⁰ Reuter P and Stevens A (2007) UK Drug Policy Commission 'Options for regulating new psychoactive drugs: a review of recent experiences'

www.ukdpc.org.uk/.../Policy%20report%20-0A%20analysis%20of%20UK%20drug%20policy.pdf

⁷¹ United Nations (2011) *Global Commission on Drug Policy Report: War on Drugs* [www.cfr.org/Drug Trafficking and Control](http://www.cfr.org/Drug%20Trafficking%20and%20Control)

Chapter 2. Is it morally wrong to take illegal drugs?

In this chapter I examine the morality of using psychoactive drugs for recreational purposes. It starts with an account of how the perception of morality in philosophy and the law has changed in recent times, with an analysis of the changes.

Next I will explore the current views of the public on drug taking, expressed through opinion polls, the newspapers and in the debate in the House of Commons in October 2014.

This leads into some comments on the importance of Relativity Theory, before the normative theories of Kant, of Consequentialism and of Virtue Ethics are used to provide a philosophical examination of drug taking and aspects of drug policy implementation. Relativism will be reintroduced to ascertain whether the philosophical interpretations might be modified.⁷²

The chapter concludes with a summary in which I express my opinion on whether it is right or is wrong to take drugs and how that knowledge might be used in counselling.

The ensuing exploration of the morality of illegal drug usage is placed in the present-day Western culture with a Judeo-Christian, ethnically white, northern European, heritage. This is my personal orientation and may result in unintended bias. However although no-one should be so vain as to claim an absolute lack of ethnocentricity, I will attempt in this dissertation to make the philosophical analysis as objective as possible.

2.1 What is right or wrong?

What will be considered first is what it means to say that something is right or wrong for what used to be considered to be right or wrong in the past, may not be so now, or in the future.

The Oxford Dictionary states:

‘Morality: concerned with goodness and badness of human character or with the distinction between right and wrong’.⁷³

2.2 The Changing Perception of Morality

It was probably the belief that drug taking was morally wrong, which might well have been behind the rhetorical speech by the Egyptian delegate to the 1925 Convention, where he was referring to opium products and hashish to be a vice to be prohibited. Indeed many people still do maintain it to be so, but in the last century many thinkers have modified their position about that and other moral matters.

An example was the ‘evil’ of homo-sexuality, as it was perceived in Britain until the Wolfenden Report of 1957⁷⁴ The belief had been that the State had the right to interfere in a citizen’s private life, and this was upheld by the opinion of Sir Patrick Devlin, Lord Chief Justice of England, who said:

“...that even private acts should be subject to legal sanction if they were held to be morally unacceptable by the ‘reasonable man’, in order to preserve the moral fabric of society”⁷⁵

⁷² Warburton N (1992) *Philosophy* Routledge, Abingdon Oxford *Right and Wrong* pp.41-61

⁷³ Fowler H W & Fowler F G The Concise Oxford dictionary 8th ed 1991 OUP Oxford

⁷⁴ The Cabinet Papers (1957) *Homosexuality, the Wolfenden Report* Lord Wolfenden chaired the Committee which recommended that homosexuality be legalise and condemned the criminalisation of homosexual acts www.nationalarchives.gov.uk/...>Law, liberty and society

⁷⁵ Dworkin R M (1966) *Lord Devlin and the Enforcement of Morals* - Yale Law School

This being the argument in favour of the prohibition of homosexuality.⁷⁶ Until H.L.A.Hart, in the famous Hart-Devlin debate⁷⁷, showed that, as John Stuart Mill had maintained, the law has no business in interfering in a citizen's private acts if they harmed no-one else,⁷⁸ the Government agreed and the law was changed in 1976.⁷⁹

Suicide too is an example of morality which has changed.⁸⁰ Previously it had been a criminal act to attempt suicide, and if a person attempted it and survived would be sent to prison, on the premise that God alone had the right to end life. It was only in 1961 that the law was changed and the act of (attempted) suicide was decriminalised.⁸¹ Holt noted that the UK was the last country in Europe to decriminalise suicide,⁸² and may be again the last to do the same for drug use. Other areas where the perception of morality has or is changing are same sex marriage, and adoption of children where both parents are of one gender.

However there are situations where the moral interpretation of freedom appears to have changed and which people generally accepting the law's interference with the citizen's liberty. The obligation for car drivers to wear seat belts and motorcyclists to wear crash helmets which also interferes with an individual's freedom because of the risk of harm to a driver and the burden of the expense to society which might be incurred through the treatment which might become necessary. So with that argument it is the duty of the State to protect the citizen. It could be argued that the ordinary person does not fully appreciate the risks; that used to be the case with cigarette smoking. What young person starting to smoke, and enjoying behaving as an adult, thinks about what might happen to them in thirty to forty years' time, and may or may not realise, perhaps not even care, that there will be a 50% chance of early death due to smoking related illness at the very time that they should be starting to enjoy their pension?

The State, upon the prompting of Public Health Medicine, has now acted with paternalism and the law by banning smoking in public places by making cigarette packets unattractive and with serious health warnings, through wearing seat belts etc. In my dissertation, *Thalassaemia Prevented...but was it ethical?* I made the case that it was

digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=4612...fss..

⁷⁶ Dworkin R M (1966) *ibid* quoted Lord Devlin the 1958 Maccabean Lecture to the British Academy, whilst talking about principles, as saying:

"We should ask ourselves in the first instance whether, looking at it calmly and dispassionately, we regard it as a vice so abominable that its mere presence is an offence. If that is the genuine feeling of the society in which we live, I do not see how society can be denied the right to eradicate it"

Later on he is quoted as saying, in commenting on the proper division between crime and sin:

"In this field its (the law's) function, as we see it, is to preserve public order and decency, to protect the citizen from what is offensive or injurious, and to provide sufficient safeguards against exploitation and corruption by others. It is not, in our view, the function of the law to intervene in the private lives of citizens, or to seek to enforce any particular pattern of behaviour further than is necessary...There must remain a realm of private morality and immorality which is, in brief and crude terms, not the law's business"

⁷⁷ Yale Law Faculty *Notes on the Devlin-Hart Debate*

faculty.ypc.edu/~dweiss/phl347.../devlin%20and%20hart%20notes.pdf

⁷⁸ Mill J S (1859) *On Liberty* p68 Penguin Books 1974

⁷⁹ House of Commons (1976) *Sexual Offences (Amendment) Act 1976*
www.legislation.gov.uk/ukpga/1976/82/section/1

⁸⁰ Holt G(2011) *When suicide was illegal* - BBC News
www.bbc.co.uk/news/magazine-14374296

⁸¹ Government Legislation (1961) *Suicide Act 1961*
www.legislation.gov.uk/ukpga/Eliz2/9-10/60/contents

⁸² Holt G(2011) *ibid*

acceptable to infringe the ethical right of self determination *a little bit*, if the *great potential gain* of avoiding the birth of a fatally disabled baby was to be achieved.⁸³

What has been demonstrated in these examples is that morality, if not fixed in ideology or in faith, is able to change. The next section will explore how this change is also occurring in the population as a whole, and what the ‘public’ might be thinking about the matter.

2.3 The public perception of the morality of drug using

However whatever the public *thinks* about drugs and what the scientists and philosophers might believe they *know* about the subject, and feel should be used as policy, may be far removed from what the politicians might *approve* of and put into law, as Professor Nutt’s experiences described above showed.

In Social Science and Medicine,⁸⁴ Gemma and Crammond (2015) postulated three streams of activity flowing through and influencing the policy making system; *problems, policies and politics*.

The ‘problem’ stream is how *issues* are drawn to the attention of policy makers; the ‘policy’ stream refers to the various *solutions* available, and the politics stream identifies the wider environment in which *political decisions* are to be taken if the solutions are to be implemented. These latter are the national mood, ideology and concerns of the community on the matter, as well as other considerations such as costs, prioritization of the political agenda etcetera. If and when there is a confluence of these streams there may present a ‘window of opportunity’ for political action to be taken.

It is the politicians who have to place into law the policy upon which they decide. They therefore have to be alert to their responsibilities in *leadership of* the community as well as their duty of *service to* the community they represent. It is a nuanced dichotomy, and the politician may be accused by their electorate either of pusillanimity if they don’t do something or of arrogance if they do, with the consequential impairment of the politician’s re-election prospects, to which they have to be alert.

This section of Chapter 2 does not deal with the Issues or Solutions of drug taking, for they are discussed elsewhere, or with the political mechanisms in parliament. It will on the other hand examine the mood of the public, the press and of parliamentarians.

2.3.1 The mood of the public

Many factors influence the views of the public about using psychoactive drugs for recreational purposes, and the methodology for investigating this will be by surveying opinion polls, newspaper reports and parliamentary debates.

The public is perhaps influenced by newspapers and the news heard or seen on the radio and television; all of these may be biased, and what people receive may be what they want to know, which may depend upon their background, circumstances, ideology, ethnicity and other factors. People also hear information in places where they meet, in

⁸³ Forsythe-Yorke W (2013) *Thalassaemia Prevented...but was it ethical?* Dissertation for the Diploma in the Philosophy and Ethics of Medicine and Health Care of the Society of Apothecaries of London
During the research for this project, I consulted the Archimandrite of the Greek Orthodox Church in London, for the subject of my research lay in Cyprus, where that faith predominates. I learned from him that it would be considered to be a greater sin to give birth to a baby, knowing beforehand that it would have a life so disabled as to be not worth living, than it would be to have the pregnancy terminated.

⁸⁴ Carey G & Crammond B (2015) *Action on the social determinants of health: views from inside the policy process* Social Science and Medicine 128(2015)134-141
<http://dx.doi.org/10.1016/j.socscimed.2015.01.024>

pubs and clubs or may listen to presentations on drugs if they have a particular interest in the matter.

Politicians also access the same information sources as the public, but additionally hear the public's mood in their constituency surgeries. Politicians will have access to specialist information to enable them to make informed choices when political decisions are to be made, balanced against the mood of the public. For as Carey and Crammond quoted

*Just because something might be printed in the Lancet or the BMJ...it wouldn't get the time of day unless it was accompanied by market research that showed what the impact of that would be in marginal seats. Thus evidence takes a back seat to issues that will win votes.*⁸⁵

What the public thinks about drugs will be examined next by analysing opinion polls.

2.3.2. The illustrative value of opinion polls

Transform⁸⁶ points out that it is important to be cautious with poll statistics, and lists the main possible sources of error and bias(j) Opinion polls found on online search do not appear to have explored the question: 'Is it right or is it wrong to take recreational drugs?' Instead asked whether people take them, how often, and which drugs they take⁸⁷. This showed(2002)that 28% of all those questioned had taken drugs at some time, and 72% hadn't. The drug most used was cannabis 73%; between 20-30% had used ecstasy, amphetamine, LSD, cocaine, magic mushroom, between 4-10% had used ketamine, crack or heroin. Of those who used drugs, 17% used them daily, 32% weekly, 19% monthly and 32% less than monthly. The first drug used was cannabis in 77% of respondents; the average age of starting was 18 years and of stopping was 23 years.*

On the question of decriminalisation 45% believed that would result in a reduction of drug related criminal activity.

Transform(2008)showed that year on year from 1988 to 2004 there is an increasing number of people supporting cannabis decriminalisation,⁸⁸ from 15% in 1988 to 64% in 2004as shown in the following bar graph⁸⁹

(j) see Annex for a discussion on potential errors in opinion polls.

⁸⁵ Carey G & Crammond B (2015) *ibid* p138

⁸⁶ Transform Drug Policy Foundation(2008) *Public Opinion on drugs and drug policy* p1
File:///C:/Users/user1/Appdata/Local/Temp/Local/DFRCRSUB.htm

⁸⁷ Observer Poll (2002) Observer Newspaper 21 April 2002
observer.theguardian.com/drugs/

⁸⁸ Transform (2008) *ibid* p2

⁸⁹ The titling of this graph shows the problem of definition; here it identifies *decriminalisation* as *legalisation of possession for personal use*. It is also pointed out that the sequence in bars does not exactly follow the sequence of years in which the polls were held. Nevertheless a clear trend of support of decriminalisation over the years is demonstrated.

* Important figures when it comes to planning for Public Health measures in risk and harm reduction programmes.

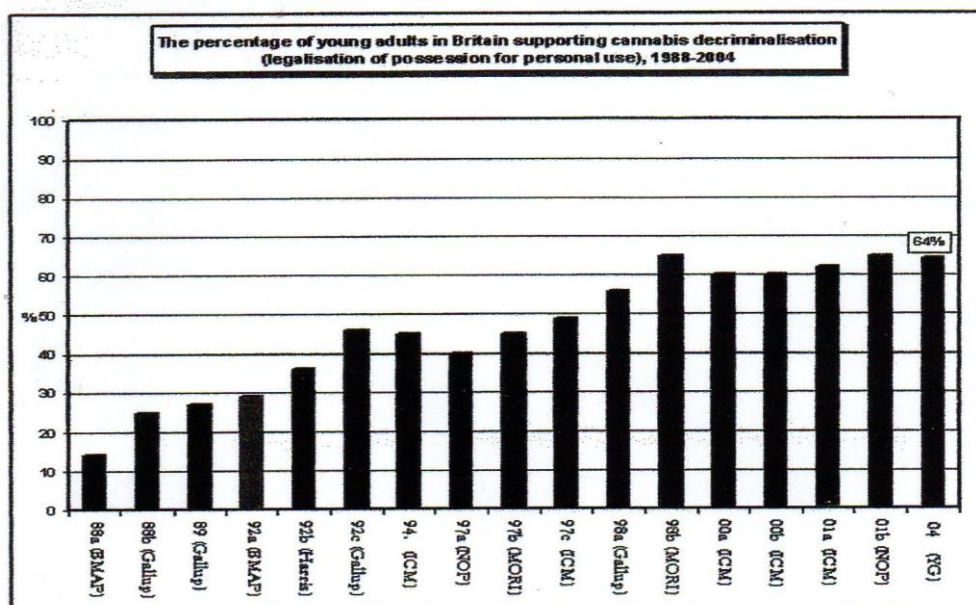


Table 10 Annual increase in young adults' support for cannabis decriminalisation

source Transform 88 (see footnote for comments)

The Observer poll of 2008⁹⁰ showed that 27% of all people in the UK (13 million) had taken drugs and of those 44% still do. Of drug takers 78% believed that they should be legalised.

Transform(2013)and the Ipsos MORI Poll ⁹¹ maintained that 53% of the population supported legalisation and decriminalisation, as did 45% of all newspaper readers (including those of the Daily Mail and Daily Express). Additionally they stated that 50% conservative and 55% labour politicians would support legalisation and decriminalisation of cannabis.

In the House of Commons debate of 2014, one of the speakers (Huppert) remarked that a poll showed 77% of MPs were in(qualified)favour of reform.⁹²

2.4The Press and Drugs

Guidelines issued to the Press⁹³ in 2012 by the Society of Editors warns journalists about the stigma gained by drug users, addicts and recovered addicts, and the prejudice and discrimination which that engenders. In the preface Dame Ruth Runciman observes that *'....social attitudes are shaped by many factors among which the media are an important influence. While reporting on issues like mental health and suicide has moved on enormously in recent years, there has not yet been a similar concerted effort to modernise coverage of drug addiction and recovery.'*

⁹⁰ Observer Poll (2008) Observer Newspaper 15th November 2008

www.theguardian.com>Society>Drug>policy

83% used cannabis as the first drug, other drugs used first were< 6%

⁹¹ Ipsos MORI (2013) quoted by Transform

www.tdpf.org.uk/campaign/changing-public-opinion

⁹² Huppert J (2014) House of Commons Hansard Debates for 30 Oct 2014 (pt 0002) UK Drugs Policy at Column 450

The observation by Dr Huppert was: *'Another survey two years ago-I cannot remember which paper ran it-showed that 77% of MPs thought we should have reform, as long as they knew they would not be named in the survey and asked to introduce it. Politicians should have the courage of their convictions, and the public's conviction, and take action.'*

* the National Newspaper Archive was the main source.

⁹³ Seymour D ed (2012) :*Dealing with the stigma of drugs; a guideline for journalists Society of Editors* (Autumn 2012) www.societyofeditors.org

The newspapers which were studied in the context of this Dissertation were the Independent and Guardian (both politically ‘middle of the road’), the Daily Mail and Daily Telegraph (both right wing inclined), the Daily Mirror which is left wing in its views, and the Huffington Post. Newspapers were studied insofar as they were available on-line through the National Newspaper Archive. Articles were found to be either reflective accounts, which will be commented on, or sensational pieces which reported extraordinary occurrences associated with drug events. These will not be discussed further.

The first piece noted was in the Independent in 1997;⁹⁴ the authors reflected on the fact that casual drug takers on the whole were independent people, progressive in their careers, active in their life and not lacking in self-esteem. Nor were they mostly undergoing treatment for the habit of drug taking. In 2007 The Independent⁹⁵, commented on speech made by the Chief Constable of North Wales, Richard Brunstrom, in which he put forward the suggestion that all drugs should be legalised. This was also the subject of an article in the Daily Mail of 2015.⁹⁶

The Mirror (2009) emphasised the costs of present day drug policy enforcement in the UK, pointing out that the national expenditure was £10 billion a year,⁹⁷ and was mainly spent on combating drug related street crime and burglary.

Reed (2015)⁹⁸ in the Huffington Post quoted the ‘Dunedin Report’ (2002)⁹⁹ calling for a degree of realism in the debate about hashish (from naturally grown marijuana) compared with ‘skunk’ (cannabis fortified with genetically modified or artificially added cannabinoids). He referred to a recent television programme when the broadcaster Jon Snow, having taken ‘skunk’ became distinctly unwell and confused,¹⁰⁰ who remarked:

“It really is true; as the rest of the world sails along with progress in their sights, the UK remains anchored to the barnacles of prohibition... we still maintain a stance of indiscriminate criminalisation. Like many, I have come to realise that the criminalisation of any person for their substance use is, frankly, a barbarous act - a sharpened shiv wielded for political intent.

We have become confused and complacent with the drug policy discussion here in the UK. The media frenzy is, at best, frustrating, and at worst obfuscates with pernicious polarisation. More often or not, if a significant research paper comes out it's matched by searing headlines to add some sizzle to the steak. In terms of media, we've reached operatic levels in spurious mishandling.”

A Mirror editorial (2012)¹⁰¹ reflects to another of 2009 (mentioned above) and the cost to the UK of the ‘war on drugs’ which it estimates to cost £20 billion a year. On a lower level it gives examples of women who have had to take to prostitution to pay for their habit. It

⁹⁴ Bennetts J & Todd B (1997) *Habits: most drug users are happy and successful people with a taste for the good life* Independent 5th November 1997

⁹⁵ Brown J & Langton D (2007) *Legalise all Drugs* Independent 15th October 2007

⁹⁶ Daily Mail editorial (2015) *Police Chief Backs Calls for Legalisation of Drugs* Daily Mail 4th April 2015

⁹⁷ Daily Mirror editorial (2009) *Calls to legalise drugs to halve crime* Daily Mirror 7th April 2009

⁹⁸ Reed J (2015) *It's time to listen to Cannabis Consumers* Huffington Post 12th March 2015

⁹⁹ Arseneault L & Cannon M (2002) *Cannabis use in adolescence and risk for adult psychosis: longitudinal prospective study* BMJ 2002 Nov 23 ;325(7374)1212-13. In which the authors report on a study of 1037 young people in Dunedin, New Zealand. They showed that cannabis smoking at age 15 years or less was likely to result in a four times higher than normal risk of the subject developing schizoid symptoms by the age of 26. At the age of 18+ years there appeared to be little increased risk. They recommended that cannabis should be avoided by young teenagers and the law should prohibit cannabis use by people until they reach 18 years.

¹⁰⁰ Selby J (2015) *Jon Snow describes moment he got stoned on 'two huge balloons' of skunk – and 'terrifying' four-hour come down* Independent 17th February 2015

¹⁰¹ Daily Mirror editorial (2012) *War on drugs can only be won by legalising them* .Daily Mirror 24th January 2012

recommends that a legal register of drug vendors should be established, with regulated outlets, licensed to sell drugs, by trained staff, of known purity and dosage.

The Daily Mail (2014)¹⁰² refers back to Hall's report in Australia (2001)¹⁰³ pointing out that with cannabis claiming one in six teenagers becomes dependent and doubles risk of developing psychotic disorders, including schizophrenia. Heavy use in teenagers appears to impair intellectual development. Driving after smoking cannabis doubles risk of having a car crash. Stating that thereby Professor Wayne Hall has '*demolished the argument that cannabis is safe*'. In his article Hall stated his researches show that harms are caused by cannabis to the individual as well as to the community; but equally there are the harms caused by prohibition.

He emphasized that the policy makers in Australia have to decide whether the costs of prohibition outweigh the benefits of preventing harms from cannabis use and he lists them as follows: possibly increased risk of accidents to user, respiratory disease, dependency, impaired adolescent development and the exacerbation of psychotic tendencies. If these could be prevented by prohibition measures that would be a benefit to society. On the other hand the cost would be that from prohibition arises a black market in drugs, ineffective implementation and disrespect for the law, the criminalisation of users and impairment to their career development, and the financial and economic cost to society.

The Daily Telegraph published a similar article¹⁰⁴, resulting in a complaint to the Independent Press Standards Organisation,¹⁰⁵ which was upheld as being inaccurate and a correction was published.

On 30th October the Home Office issued its Report¹⁰⁶ (but with no recommendations) following visiting eleven countries to study their drug policies. The Guardian¹⁰⁷ & ¹⁰⁸ welcomed the Report as did the Independent. The 'tide is beginning to turn' was the comment in the Independent,¹⁰⁹ pointing out that in Portugal, since the partial decriminalisation there in 2001, drug usage and drug deaths have fallen not risen as many predicted. Moreover there appeared to be no relation between the 'toughness' of a drug policy and drug use by adults. The Independent's editorial on the same day welcomed the forthcoming Debate in the House of Commons.¹¹⁰ The paper's 'Comment' column wrote

¹⁰² Spencer B (2014) The terrible truth about cannabis: Expert's devastating 20-year study finally demolishes claims that smoking pot is harmless. Daily Mail 6th October 2014

¹⁰³ Hall W (2001) *Reducing the harms caused by cannabis use: the policy debate in Australia*. Drug and Alcohol Dependence 2001: May 1; 62(3):163-174

¹⁰⁴ Daily Telegraph editorial (2014) *Cannabis as addictive as heroin* Daily Telegraph 7th October 2014

¹⁰⁵ Independent Press Standards Organisation (2014) *Resolution statements - Detail Complaint 01148-14 Reynolds v. The Daily Telegraph ... headlined "Cannabis on a par with Heroin"*
<https://www.ipso.co.uk/IPSO/rulings/resolution-statements/detail.html?...>

¹⁰⁶ Home Office (2014) *Drugs: International Comparators*
<https://www.gov.uk/government/.../DrugsInternationalComparators.pdf>. The Report summarised as follows:

'This study has provided us with a sound base of evidence on approaches to drugs misuse and drug addiction in other countries, and we hope that this report makes a useful contribution to the global debate on drug policy. Based on what we have learned, the UK will continue to advocate a balanced, evidence-based approach to the misuse of drugs internationally'

¹⁰⁷ Travis A (2014) *Eleven countries studied, one inescapable conclusion- the drug laws don't work*. Guardian 30th October 2014

¹⁰⁸ Editorial Guardian (2014) *Drugs Policy. Official: tough or tender, drugs policy does affect the amount of drug abuse. But tough costs more* The Guardian 30th October 2014 p34

¹⁰⁹ Morris N & Wright O (2014) *Drug Abuse: but is Britain ready to grow up?* Independent 30th October 2014 '*The first Commons debate for a generation offers rare chance for honest discussion. Suppressed Home Office report casts doubt on current punitive approach*'

¹¹⁰ Independent editorial (2014) *Addicted to ignorance; let common sense prevail when-at last-the Commons opens itself up to a debate on drugs*. The Independent 30th October 2014

of the possibilities that the Report and Debate offered.¹¹¹ The Daily Mail by contrast quoted the Prime Minister as saying: “...*what we are doing is working. I don’t believe in decriminalising drugs which are illegal.*”¹¹² The paper ran other piece¹¹³ referring back to the one printed on 6th October see footnotes 121&122, and a further one criticising Nick Clegg the deputy Prime Minister’s support for decriminalisation.¹¹⁴

On 31st October 2014 the House of Commons debated ‘UK Drugs Policy’,¹¹⁵ which will be discussed in the next section of this chapter. The disparaging comment from Palmer of the International Business Times was that there was a very sparse attendance of Members of Parliament at the debate; 21 only of the possible 650 MPs turned up to debate the matter.¹¹⁶(k)

2.5 The House of Commons Debate 30th October 2104

The House of Commons *Debate UK Drugs Policy* was held on the same day that the Home Office Report *Drugs: International Comparators* was published. Thus there was little time before the debate for it to be considered by parliamentarians, except for those who had taken part in the visits to study drugs policies in other countries, and had themselves contributed to the Report.

Twenty one members of parliament attended the debate¹¹⁷, 3% only of the 650 total in the House. Whether the small attendance was indicative of lack of interest, or wariness of the political risks of the subject, with an election only seven months ahead, may only be conjectured. No ‘front bench’ MPs from any party took part. How valuable the debate might have been in reflecting the views of Parliament overall or indeed of the MPs’ constituencies might also be questioned. As mentioned above, one of the speakers, Dr Huppert, remarked that a couple of years previously, in favour of a change were 77% of MPs, *as long they weren’t identified*.

Before the debate the Prime Minister¹¹⁸ and afterwards the Home Secretary¹¹⁹ had expressed their views that they were satisfied with the status quo.

¹¹¹ Murkin G (2014) *This opportunity for reform must not be wasted*. The Independent 30th October 2014

¹¹² Press Association (2014) *Drug policy is working* Daily Mail 30 October 2014 the piece went on to say David Cameron today hit back at LibDem calls to be decriminalised. “*It would encourage children to get hooked.*”

¹¹³ Daily Mail Comment (2014) *Clegg and a deadly gamble over drugs* (Daily Mail 30 Oct 2014)

¹¹⁴ Groves J, Drury I & Doughty S (2014) *Clegg aide tried to spin drug report; he urged BBC to give airtime to lobbyist who want legislation* (Daily Mail 30 October 2014)

¹¹⁵ House of Commons (2014) *Hansard Debates for 30 Oct 2014 (pt 0002)* Column 434 et seq

¹¹⁶ Palmer E (2014) *Only 21 out of 650 MPs Attend Parliamentary Debate on UK Drug Laws* International Business Times 31st October 2014 www.ibtimes.co.uk/only-21-out-of-650-MPs-attend-parliamentary-debate

(k) see Annex A for photograph of the debate.

¹¹⁷ The Members of Parliament who spoke were

Green Party :Lucas

Independent :Hancock

Conservative: Syms, Goldsmith, Wollaston, Barclay, Lilley, Blunt, Phillips, Ollerenshaw, Stewart

Labour: Cunningham, Flynn, Vaz, Abbott, Johnson

Liberal Democrats: Huppert, Thornton, Swales, Baker,

¹¹⁸ Wintour P (2014) *Drugs legalisation: Cameron stands firm despite Lib Dem pressure* Guardian 31 Oct 2014 referring to the Prime Minister’s rejection of the Home Office Report’s suggestions that UK Drug Policy needs revision

¹¹⁹ Sparrow A (2014) *Norman Baker reveals drugs proposal Theresa May stripped from Report* The Guardian 26 Dec 2014. The article commented that ‘*No 10 said at the time that government drug policy was working and there was nothing in the Home Office report that showed the government had to change tack. But Baker revealed on Friday that the original draft had contained policy recommendations that, on May’s orders, had been removed prior to publication*’

The debate was initiated by Ms Caroline Lucas, (Green Party), who proposed:

*“that the House notes that drug-related harms and the costs to society remain high”*¹²⁰.

She went on to say that in the UK about £3billion were being spent annually on drug policies which are often counterproductive, and to pursue an effective drugs policy an evidence based approach is required. She referred to the Report on International Comparators and suggested that the UK with its failing drug laws should learn from drug policies adopted in other countries.

Ms Lucas observed that the Report on International Comparators indicated that if drug addicts were to be treated rather than jailed that would save millions of pounds; a move of the drug policy to the Department of Health would be the first step to a harm reduction approach rather than rely on punishment.¹²¹ She also pointed out that poverty, social exclusion and inequality all have an impact on drug usage, and that ending social exclusion must be at the heart of any effective strategy.¹²² She added that the world’s drug trade has been handed over to villains, is completely uncontrolled and has caused untold ill-health and misery. She felt that the current drug policy in the UK is based on ignorance of the facts.¹²³

Ms Lucas then dwelt in detail on the case of the death of Martha,¹²⁴ pointing out that prohibition far from stopping her taking risks, had made those risks much more dangerous. A drug policy needs not only to deter young people from taking drugs, but also needs a regulatory model which reduces the risk if they do. Apart from the effects of drugs on people, the policy drives people to burglary and theft, and there is great potential to reduce such crimes and their impact on society. The law may result in reducing the supply of conventional drugs, but then people turn to ‘legal highs’, and that too increases the risks, for the users might know even less about what they may be taking.

The speaker concluded her presentation by stating that from the evidence gathered from other countries, the UK could have a very different drug policy and that it was incumbent upon Members of Parliament to make the UK policy more effective.¹²⁵

During the debate which followed all speakers spoke in favour of the motion save one (Dr Wollaston) who expressed reservations and pointed out that cannabis was less harmless than is often thought, and may significantly increase the risk of schizophrenia.¹²⁶ (y) She also observed that cannabis usage among young people had been falling in recent years,¹²⁷ which was countered by another member (Swales) who observed that the use of legal highs among young people was simultaneously rising.

Other members spoke about the need for a policy based upon evidence and effectiveness, that the current policy is very expensive and the costs could be better spent. One member (Phillips) emphasised that £4billion(u) annually is poured into the criminal justice system to deal with drug matters, money which could be spent better.¹²⁸

The relationship between poverty, inequality and social exclusion was discussed, with prohibition causing crime. Five members stated that drug policy would be better handled by the Department of Health and not by the Legal Department. Several MPs felt that the

¹²⁰ House of Commons (2014) *ibid* Column 434

¹²¹ House of Commons (2014) *ibid* Column 435

¹²² House of Commons (2014) *ibid* Column 436

¹²³ House of Commons (2014) *ibid* Column 437

¹²⁴ Stanford P (2014) *What Martha’s sad death can teach us* D.Telegraph 15 March 2014

¹²⁵ House of Commons (2014) *ibid* Column 339

¹²⁶ House of Commons(2014) *ibid* Column 441 (y) See Annex A for a detailed account of cannabis.

¹²⁷ House of Commons (2014) *ibid* Column 440

¹²⁸ House of Commons (2014) *ibid* Column 463 (u) See Annex for other estimates.

risk of taking drugs would be reduced if there was a regulated and controlled market, especially with the increasing use of ‘legal highs.’ Lilley expounded on this in some detail.¹²⁹

Ms Lucas closed the debate by expressing regret that so many of her ‘...*colleagues not yet persuaded of the argument were not here to hear them,*’ and felt they would probably have concurred with the proposals. She said that the tide of public opinion is changing and that a poll conducted that day showed that 71% of the public think that the ‘war on drugs’ has failed. She commented on the fact that the Government has noted the effectiveness of the alternative policies of other countries.

In conclusion she called upon

*‘...the Government to conduct an authoritative and independent cost-benefit analysis and impact assessment of the Misuse of Drugs Act 1971 and to publish the results of those studies within the next 12 months.’*¹³⁰

2.5.1 Newspaper comments following the Debate

The Independent reported favorably on the debate and on the consensus of agreement by the Members of Parliament.¹³¹ Three days after the debate the Mirror,¹³² opined that relaxation of prohibitive measures would adversely affect society. Conversely the article did have an opinion poll on legalisation, which showed that 75% of its readers were now in favour of it.

Westbrook¹³³ in the Daily Telegraph quoted reports from Sidney, Australia that a city councillor there suggested drugs should be available under regulated conditions ‘over-the-counter’ for confirmed addicts, pointing out that then they would know the dose and be confident of the purity of what they are getting. Other councillors dismissed the idea as madness. The Telegraph article also quoted Dr Vincent Wodak, of St Vincent’s Hospital, Sydney, as saying the proposal was helpful to the debate, for it would be like the therapeutic use of the opioid methadone in the treatment of heroin addiction.

The Independent reported in January 2015 on the experience of cannabis one year after decriminalisation in Colorado. There had been a fall in drug related crime and the drug usage rates, which had been falling before decriminalisation started, were still falling especially amongst young people.¹³⁴

The use of ‘skunk’ (fortified cannabis) was commented on in the Mail on Sunday,¹³⁵ reported on the research at the Institutes of Psychiatry at King’s College London which advised that there was an ‘*urgent need to inform young people about the risks of high-potency cannabis*’ amid the world-wide trend towards relaxing drug laws. It pointed out that fortified cannabis may precipitate psychosis or reveal a previously latent condition. The Report in the Mail added that ‘*those who used the weaker forms of hash did not seem to suffer the same increase in risks*’. The Lancet reported this research on 18th February, commenting on the findings that use of ‘skunk’ in people studied (18-65 year olds) resulted

¹²⁹ House of Commons (2014) *ibid* Columns 445&446

¹³⁰ House of Commons (2014) *ibid* Column 475

¹³¹ Morris N (2014) *The drug revolution starts now as MPs agree it’s high time for a change* Independent 30Oct14

¹³² Malone C (2014) *Legalising drugs will not solve problems, just destroy our children.* Daily Mirror 1st

November 2014 At the foot of the article the Mirror poll showed that now 75% of the population feel that drugs should be legalised.

¹³³ Westbrook T (2014) *Insane plan to legalise drug ‘ice’ (crystal meth)* Daily Telegraph 12Dec2014

¹³⁴ Hooton C (2015) *One year after legalisation in Colorado there is no increase in crime* Daily Telegraph 20th January 15

¹³⁵ Adams S (2015) *Scientists show cannabis TRIPLES psychosis risk. Groundbreaking research blames ‘skunk’ for 1 in 4 of all new serious mental disorder* Mail on Sunday 15th February 2015

in an associated 24% higher risk of first episode psychosis.¹³⁶ The Mail had a further report in February in support of the medicinal use of cannabis,¹³⁷ and repeated this in April.¹³⁸

A poll reported in the Daily Mirror in March that 88% of the population were now in favour of cannabis decriminalisation, and cited Portugal's experience of falling numbers of drug users among 16-25 year olds, since the drug policy changed there in 2001.¹³⁹ In April 2015 the Daily Mail hitherto in the forefront of the anti-decriminalisation and anti-legalisation discussion ran several articles in favour of it, quoting the Chief Constable of North Wales recommending that some drugs should be legalised and that those drug users engaged in street crime and burglary should be referred to treatment rather than punished.¹⁴⁰ The paper also ran an article in which Lilley (a previous Conservative front bench) who had spoken in the Debate suggest licenses should be issued to over 18 year old drug users, and that cannabis plant culture should be allowed for personal use. It cited an article in the Lancet that moderate usage had no ill effects, and that cannabis use did not lead on to the use of hard drugs¹⁴¹. Further pieces appeared in the Daily Mail on 28th April, which were *not* critical of the Deputy Prime Minister.¹⁴²&¹⁴³

The press in the UK has come far since 2009,¹⁴⁴ and 2011 with the vituperation at the time against proposals to amend the laws on drug usage.¹⁴⁵

The position of the 'people' on drugs, legalisation and decriminalisation has changed and still in changing significantly towards an alternation of drug policy. How much of this may be attributable to instinctive moral reasoning and how much is simply an expression of common sense and of reality could be debated. The position now described leads into the philosophical analysis which follows next.

2.6 Moral Relativism and Drugs

Morality, that is the rightness and wrongness of a situation, on the whole, is considered by some philosophers, but not by all, to be relative to the time period and culture of the community under discussion. This relativity of morals is described under three headings: descriptive, meta-ethical and normative relativism(l)

¹³⁶ Di Forti M et al Lancet 18th February 2015

¹³⁷ McTague T(2015) *Let people smoke cannabis if it helps them cope with their medical problems, says Deputy PM Nick Clegg* (Daily Mail 19 Feb 2015)

¹³⁸ McTague T(2015) *Clegg said cannabis should be allowed in treatment of symptoms* (Daily Mail 12 April 2015)

¹³⁹ Warnes S (2015) *Should we decriminalise drugs? Yes says Richard Branson and Nick Clegg* (Daily Mirror 5 March 2015)

Portugal's drug usage by 16-25 year olds

	2001	2007	2012
Cannabis	3.3%	3.6%	2.77%
Cocaine	0.3%	0.6%	0.2%
Amphetamine	0.4%	0.2%	0%

¹⁴⁰ Daily Mail Online (2015) *Police Chief calls for legalisation of drugs* (Daily Mail 4 April 2015)

¹⁴¹ Daily Mail Online (2015)*ibid Lilley's call to legalise cannabis welcomed*

¹⁴² McTague T (2015) *Clegg 'open minded' about high street cannabis.* (Daily Mail 28 April 2015)

(i) an example in my personal experience is described at Annex A (i); Barbara Copeland's Story

(l) Details of Relativism are given at Annex A, together with a brief comment on Reflexivity

¹⁴³ McTague T (2015) *Nick Clegg makes election vow to decriminalise cannabis* (Daily Mail 28 April 2015)

¹⁴⁴ Phillips M (2009) *Fatuous, dangerous, utterly irresponsible - the Nutty professor who's distorting the truth about drugs.* (Daily Mail 4Nov2009)

¹⁴⁵ Phillips M (2011) *Drug legalisation?We need it like a hole in the head* (Daily Mail 19 Nov 2011)

These three aspects of relativism have been summarised by Sommers and Sommers thus¹⁴⁶

'...individuals are right or wrong depending upon the nature of the society from which they emanate, and are so by the context in which they occur. Thus the moral principles are relative to a culture's belief, history, etc.' (m)

However this moral relativistic approach may be counter argued by the absolutist viewpoint that

*'...there exist universal moral principles and human rights which supersede relativism...there is the issue of female circumcision, a procedure condoned, even encouraged by Sudan's current ethical policies. It is a procedure which is harmful and dangerous and against the victim's will. If it is, then it would be morally wrong to force unnecessary suffering upon others. This is a universal, objective moral truth',*¹⁴⁷

yet the meta-ethical analyst might claim that logically only the people concerned in the Sudan are able to make that judgement.

It could be said that what they do there is their business and none of ours. The same argument might apply to what happened in the 'Holocaust' in Germany towards the end of the Second World War, which might be construed as 'none of our business'. In fact it could be even justified by the hedonistic pleasure presumably gained by the warders in the prison camps.

Or indeed by the utter conviction of the Nazi hierarchy that they had a duty to exterminate a race of people whom they deemed to be worse than vermin. Thus the argument ends in philosophical poverty and incoherence.

Moral absolutism is found in some philosophical circles, yet to others all views are relative. To a believer it is certain to be found in Scripture, being there derived from Divine Command.

The papal encyclical *Veritatis Splendor*¹⁴⁸ asserts that there are indeed absolute truths accessible to all persons. Contrary to the philosophy of moral relativism, the encyclical insists that the moral law is universal across peoples in varying cultures, and is in fact rooted in the human condition. Pope John Paul teaches that no matter how separated someone is from God:

"...in the depths of his heart there always remains a yearning for absolute truth and a thirst to attain full knowledge of it."

Fortunately for the non-believer not versed in the niceties of philosophy, there is also *The Universal Declaration of Human Rights*¹⁴⁹ a milestone document in the history of human development. Drafted by representatives with different legal and cultural backgrounds from all regions of the world, the Declaration was proclaimed by the United Nations General Assembly in Paris on 10 December 1948. It sets out, for the first time, how fundamental human rights are to be universally protected, and provides a list of them.

(m) see Annex A for an anecdote about a personal experience of this.

¹⁴⁶Sommers C H & Sommers F (2007) in *Vice and Virtue in Everyday Life* 7th ed Canada Thomson Wordsworth quoted in Walsh K· *Moral Absolutism: a Response to Relativists* p70 University of New Hampshire cola.unh.edu/sites/cola.unh.edu/files/student.../6_Moral_Absolutism.pdf

¹⁴⁷ Fleur-Lobban C in Walsh K *ibid* p 74

¹⁴⁸ Pope John Paul II (1993) *Veritatis splendor, Encyclical Letter* Introduction, para 1 www.vatican.va/.../hf_jp-ii_enc_06081993_veritatis-splendor_en.html

¹⁴⁹United Nations (1948)*Declaration of Human Rights* en.wikipedia.org/wiki/Universal_Declaration_of_Human_Rights

The *Universal Declaration*, with all its wisdom, is not *necessarily* the last word on the matter, for the opinions of even wise people may change. In the 1925 Convention where the opinion was voiced that

*'Taking hashish is a vice, a sign of weakness and of dissipation.'*¹⁵⁰

whilst the International Opium Convention(1912) recommended everything connected with drugs of addiction should be prohibited and criminalised. Now the mood is changing and the UN is to hold a Convention on the premise that prohibition has failed and the whole matter should be re-examined. For the ordinary worker in the field of drug addiction it should be reasonable to accept that the Universal Declaration, based upon the opinion of so many wise people, *is* the last word (for the present, that is.)

How relativism is to be taken into account will be considered once the morality of drug taking has been explored using the normative ethical theories

2.7 Is it morally¹⁵¹ right to take illegal drugs?

Three ethical 'tools' will be used: Duty based ethics, Consequentialism and Virtue Ethics.¹⁵² In this section I will end by attempting a synthesis of them.

Kantian Duty based ethics

- 1 An action is right if it is in accord with a moral rule or principle
- 2 A moral rule is one that
 - a. is laid on us by God
 - b. is laid on us by reason
 - c. would be chosen by all rational beings

Consequentialism

- 1 An action is right if it promotes the best outcome
- 2 The different consequences have to be morally evaluated and ranked

Virtue Ethics

- 1 An action is right if it is what a virtuous person would do
- 2 A virtuous person is one who exercises the virtues
3. A virtue is a character trait a person needs if he is to flourish

Duty based (deontological) ethics are characteristically of divine origin, (the Ten Commandments or the Sermon on the Mount for example), or those which are based upon the teaching of Immanuel Kant and mainly on his two best known formulations which he called 'categorical imperatives' (given below in the section dealing with Kant.) Both are relevant to the morality of drug taking and will be used in the assessment to be described. Kant's philosophy is that the motive and duty is what is important in a moral action, and that the sense of duty originates in a person's conception of self-lawfulness and innermost conscience.¹⁵³ Kant considers only the motive of an action important, not the process or its outcome.(n)

¹⁵⁰ see Chapter 3 and arguments for and against prohibition

¹⁵¹ Encyclopaedia Britannica describes how the rightness and wrongness of an action may be explored with Normative Ethics. This seeks to determine how basic moral standards are arrived at through two philosophical categories: the deontological and the teleological. The first through actions being inherently right and implies concepts of obligation and duty. The teleological approach advocates morality because the outcome or consequences of an action are good. This is the background to the chapter.

¹⁵² Warburton N (1992) .*Philosophy: right and wrong* pp38-65 Routledge, London

¹⁵³ a translation of the German is given at Annex A (n)

Consequentialism ; the ethical theory based upon the outcome of an action. Thus if the outcome is good the moral path to that outcome is also good. So Bentham¹⁵⁴ argued that the object of life is happiness, and Locke¹⁵⁵ and others defined that more closely into ‘higher forms of happiness’, which are intellectual and ‘lower’ physical ones. A development of the consequentialist theory is utilitarianism; whether the action does you good or bad, and out of that arose John Stuart Mill’s ideas of the citizen’s liberty vis-à-vis the State’s demands and this will be explored in that section of this dissertation.

Virtue ethics is based upon the concept that if what one does is virtuous the reward will be *Eudemonia*, or ‘flourishing’. Virtue Ethics in the context of this dissertation will concentrate not only on the virtues a drug taker will need, but also of those close to them¹⁵⁶ and family and the State/medical advisor as well, in their responsibilities towards the drug user. Virtue Ethics depends on the quality of character of a person engaged in an act; it is the morality of the process not the motive or the outcome of an act.

2.8 The Kantian perspective on Drugs

What will be examined in this section is how Kant’s duty based ethics helps one to understand the morality of illegal drug taking.

Immanuel Kant¹⁵⁷ emphasized the moral right of an autonomous and rational person to the self-determination of their own destiny. He saw the individual’s right to autonomy coupled with respect for the autonomy of others, and the duty not to interfere in other people’s lives, assuming of course that they are not interfering with yours.

Korsgaard¹⁵⁸ put it thus:

‘...the Kantian ideal is of free and non-manipulative relations between human beings’

Those elements of Kant’s philosophy which will be drawn on here are the two categorical imperatives

Act only on that maxim which you can at the same time accept that it should become a universal law

Act to treat humanity, whether in your own person or in that of another never as a means, but always as an end in itself.

Thus Kant emphasizes a person’s moral duty is to do what is right under all circumstance and at all times. Furthermore one has the duty to respect the dignity of all people including oneself at all times.

Kant also points out that the origin of the sense of duty, a fundamental aspect of morality, arises from a person’s own concept of lawfulness, which everyone is able to recognize in their own conscience.

¹⁵⁴ Bentham J(1724-1832) in Warburton N (1992) *ibid*

¹⁵⁵ Locke J(1632-1704) *ibid* p111 et seq

¹⁵⁶ *There is always a problem with defining who that is. In English a variety of words are used: spouse, partner, husband/wife, nearest-and-dearest, neighbour, friends, family circle and so on. Kant used the expression ‘Der Nächste’, literally the nearest and next person to you, which could be any of the above, yet could just as well be the drug-addled tramp in the door-way you are passing by on the way to your car after a good meal in a restaurant. Martin Luther in his translation of the Bible uses that expression in the Parable of the Good Samaritan. I am told on good authority by my friend the Reverend Hugh Edgell that the original Greek word was πλησίον (St Luke’s Gospel Ch10 vv25-37), translated ‘neighbour’, but meant in the collective sense as in German rather than as in English.*

¹⁵⁷ Kant I (1724-1804) *ibid* p41 et seq

¹⁵⁸ Korsgaard C(1996) *Two arguments against lying* in *Creating the Kingdom of Ends* Cambridge University Press ISBN 9780521499620

Kant's teaching might support rejection of laws prohibiting people's rights to control their own lives if they are rational enough to do so. If they are not because of youth or mental inability, then paternalism is justified.

For the individual user, taking psychoactive drugs may be considered in two phases
the phase of casual use

most people who use recreational drugs stay in this phase. As described in Chapter 1, of cannabis users, 87% remain casual users, and do not become addicted.

the addiction phase

most people do not become addicts, but if they do, then their rationality may become affected.

2.8.1 Casual use of psychoactive drugs

Using a psychoactive drug has its risk; it might become addictive. If you are using such a drug, say Ecstasy or LSD to have a 'high', is that self-gratification morally bad?

Kant offers a suggestion:

*'Enjoy life! Don't deprive yourself so much that you make yourself miserable.'*¹⁵⁹

but goes on to warn the reader about drugs:

*'Stupefying agents such as opium and other products of the plant kingdom . . . are misleading in that they produce for a while a dreamy euphoria and freedom from care, and even an imagined strength...'*¹⁶⁰

For then the user is exploiting themselves, which is immoral, for the person is using their body as a means for self gratification. Indeed Kant considers the matter *foolish*, especially when he writes of the risk of addiction. For we have a duty not to make ourselves:

'...incapacitated for activities that require adroitness and deliberation in the use of our powers.'

In other words one has a duty to respect and not undermine one's rationality, and dignity. But then Kant also goes on to say that drinking and eating should be always done in moderation; for immoderate behaviour is to be avoided, and sufficiency should be the aim¹⁶¹. Thus the 'foolishness' may be somewhat less so if a person only has a 'spliff' from time to time. And if this human fallibility is conceded to only occasionally, that may be morally acceptable. It could not be said to be a 'universal law' to forbid occasional fallibility and foolishness.

¹⁵⁹ Kant Immanuel (1724-1804) *Kanteth* - Personal.kent.edu/~jwattles/kanteth.htm from *Metaphysics of Morals* MM 484-85(93- 96)

¹⁶⁰ Kant Immanuel *ibid* MM 427-28(88-90) here Kant wrote: *'What's wrong with getting drunk, using drugs, and gross overeating? Everyone (quite properly) wants to be happy. To be healthy is an important part of happiness, and thus it is a matter of prudence for a person to use good judgment about eating and drinking. It's foolish to act contrary to prudence. Stupefying agents such as opium and other products of the plant kingdom . . . are misleading in that they produce for a while a dreamy euphoria and freedom from care, and even an imagined strength. But they are harmful in that afterwards depression and weakness follow and, worst of all, there results a need to take these stupefying agents again and even to increase the amount. . . . [They] make one taciturn, withdrawn, and uncommunicative. Beyond this counsel of prudence, however, are moral considerations.'*

We have a duty not to make ourselves temporarily incapacitated for activities that require adroitness and deliberation in the use of our powers'.

¹⁶¹ Kant Immanuel *Sammtliche Werke* herausgeben von Karl Rosenkranz & Friedr. Wilhm. Schubert III Theil Leipzig 1838

2.8.2 Psychoactive drugs and addiction.

A person, who through the use of drugs has slipped into addiction, may be impairing their rational and intellectual self, autonomy, and dignity. Kant puts one's obligation to oneself thus:

*'You have a duty to cultivate your highest intellectual capacities, your broader faculties of mind, and your physical abilities....'*¹⁶²..the ultimate moral command is "Be perfect". We frail human beings, however, cannot attain perfection in this life .Therefore the command to be perfect must be interpreted to mean, "Strive for (moral) perfection"¹⁶³

The extrapolation of this principle is that the drug addict is misusing their mind and body as a means to the end of self gratification of their addiction. Kant's universal maxim here would be to exercise oneself not to risk the impossibility of attaining moral perfection.

The moral situation becomes clearer if the person with addiction starts to develop symptoms, and is then definitely harming their rational self, and that would be clearly unacceptable and contrary to both categorical imperatives.

In summary, Kant's opinion is clear: a person has a moral duty not to harm themselves. Thus occasional indulgence would be acceptable, but more than that for where risk of addiction may be incurred it would not be moral.

So far only the moral implications for the illegal drug taker themselves has been taken into account , and attention will now be directed to the drug user's 'neighbour'.

2.8.3 The moral situation for others

. There is of course also to be considered the duty of drug taker's 'neighbour', the local community and the State. Kant deals with this in considerable detail, not specifically in respect of drug addicts but referring to people in need of help. This might be said to be his interpretation of the Parable of the Good Samaritan, and Kant himself refers to

'passages of Scripture which command us to love our neighbour and even our enemy' ¹⁶⁴

Kant also illustrates that in: '*Von der Liebespflicht gegen andere Menschen*' (Concerning the duty of love towards other people) where he stated that such a sense of duty to others is based on the feelings of affection (*Liebe*) and respect(*Achtung*). So the Kantian guidance would be that it would be morally desirable to show a duty of care in that way to the addict.

The addict's doctor's duty is clear. The doctor would be expected to have the Kantian sense of duty to his 'neighbour' and would also have his separate professional duty. If the doctor is consulted for something unrelated to addiction and senses that the patient is 'on drugs', it would not be obvious whether comment should be made to the patient about that or not. A doctor is obliged by professional duty to do the best possible for the patient, and has to make the difficult decision whether the risk of causing offence through what might be construed to be intrusive paternalism would alienate the patient, or whether the

¹⁶² Kant Immanuel ibid MM444-46(108-110)

¹⁶³ Kant Immanuel ibid MM446-47(100-111)

¹⁶⁴ Kant Immanuel Grundlegung zur Metaphysik der Sitten GMM 399(12)

www.worldcat.org/title/...kants-grundlegung...metaphysik.../491243085

'For love as an inclination cannot be commanded; but beneficence from duty, when no inclination impels us and even when a natural and unconquerable aversion opposes such beneficence, is practical and not pertaining to emotional love. Such love resides in the will and not in the propensities of feeling, in principles of action and not in tender sympathy; and only this practical love can be commanded'

patient, too scared in themselves to start to discuss the matter with the doctor, might be happy to grasp the life-line offered. It would depend upon the doctor's skill and experience in detecting those subliminal messages that would determine what should best be done.(o)

If the patient is showing bizarre or abnormal behaviour which might be an indication of drug addiction then the doctor's professional duty is straightforward and is to act in the patient's best interests. Might the doctor's sense of professional duty be interpreted in a Kantian manner? It is not unreasonable to suppose that it was an inherent feeling of duty, a feeling of vocation, in the manner of Kant's 'innermost feeling', of ethical *duty* and *love* for the 'neighbour' which took a young person into thinking about being a doctor in the first place,¹⁶⁵ and in particular if they are to specialise later in Public Health Medicine which is so heavily dependent upon the Kantian ethic.¹⁶⁶

The role of society also needs to be defined. It might be too much to expect the ordinary 'man in the street', to have a sense of duty to the down and out druggie, dishevelled and homeless sitting in a doorway. Should people collectively feel 'a duty of love' towards him? Yes, for as Kant points out¹⁶⁷

'...and so towards poor people, we also recognise our duty.'

and goes on to emphasize that the person exercising that duty has to take great care to show respect and not to cause the recipient to feel patronised in any way, or to come to feel under an obligation to the duty giver.

Concerning the 'State', that is the Government, Kant appears at first sight to be mute; nothing relevant is to be found in his writings on the '*Rechtsstaat*' (State based on the Law), which is more concerned with measures to prevent the State interfering in the citizen's life, rather than coming to their aid when help is needed.

It might be considered reasonable to extrapolate Kantian philosophy, for where Kant outlines the duty of 'people', he uses the pronoun 'we' frequently and that collectively seems really to be synonymous with the State, the government that is, acting on behalf of its citizens¹⁶⁸. And it might be speculated that was what he would have written if he had thought of it. It might be felt to be unreasonable for Kant to have thought otherwise. But the way is obvious in Hobbes¹⁶⁹, who pointed out that citizen and state have a mutual duty towards each other, if they want to live peaceably with each other.

(o) see Annex (o) for a discussion on Paternalism

¹⁶⁵ Kant Immanuel *ibid* MM 446-47 (110-111) *Ethical duties to others*#24&25 in which he wrote:

'In this context, "love" as a duty does not refer to an emotion but to benevolence which leads to beneficence'

¹⁶⁶ Holland S (2007) *Public Health Ethics* .(University of East Anglia Library)

Kant's moral theory is deontological because it is based on what he called 'the categorical imperative', i.e., the view that morality comprises a set of duties.

¹⁶⁷ Immanuel Kant: Werke in zwölf Bänden. Band 8 *Erster Abschnitt. Von der Liebespflicht gegen andere Menschen...* (First Section. Concerning the duty of love towards other people) pp 584-600 Wilhelm Weischedel. Frankfurt a.M. Suhrkamp 1977

www.zeno.org/.../Kant,+Immanuel/...gegen+andere/... and see Annex A (j) for Kant's views

¹⁶⁸ *It was in the after-era of the 18th Century 'Time of Enlightenment'; Josef II of Austria, Peter the Great of Russia and Frederick the Great of Prussia had all moved health care from the Church's responsibility to that of the State. Johann Peter Franck (1745-1821) District Medical Officer in Baden and later Professor at several universities had initiated a cradle-to-grave State-funded health service, health promotion, and education on health matters, healthy housing and food, child care, and medical care and licensing of health care professionals (In effect a blue-print of the National Health Service to come in the UK a hundred years later). This would have been the medical environment in East Prussia in which Immanuel Kant was growing up.* (from Porter R. (1997) *The Greatest Benefit to Mankind; A Medical History of Humanity from Antiquity to the Present* Fontana Press and from other sources)

¹⁶⁹ Hobbes Thomas (1588-1679) *Leviathan* Chapter XIX Penguin Edition (Norwich City Library)

A citizen has a duty to the State to be a good citizen contributing to the State's welfare, through remaining a productive person and paying taxes¹⁷⁰. Why? It would be most likely that the drug addict wouldn't be able to do so if they became severely disabled through drug addiction and the secondary illnesses which might result. The addict would need treatment, perhaps detoxification or hospital admission, and would become a financial burden to the State, but then it would also be the State's duty to care for the addict.

Kant made it clear that the State has a duty of justice towards its citizens.¹⁷¹ It might not be too far-fetched to combine the spirit of don't refer to footnotes, if you need this detail include it in the main text and interpreting Kant in today's context to imply that he would have seen the State's duty not only in justice but also in health.¹⁷²

To summarize the analysis using Kantian theory: a person has a duty to themselves and to others not to willfully and knowingly exploit and damage their rational self or intellect. Thus it would be *foolish* morally to casually take psychoactive drugs, for recreational purposes.

Addiction by contrast is morally *wrong*, even for those persons managing a normal daily life, for the person's rationality is being, or has already been harmed, and that is undesirable both for the individual and is not a situation which would be accepted universally as desirable.

The addict's 'neighbour', society, doctor, and State have a moral duty to come to the addict's aid if it is necessary to do so. If that is being considered, the balance between an addict's autonomy (a person dependant on drugs has not necessarily impaired rationality) and the risk of the neighbour being paternalistic (or being perceived as such) is always present.

¹⁷⁰ Barton R (2015) *The Ethics of Taxation* Philosophy Now Issue 90

https://philosophynow.org/issues/90/The_Ethics_of_Taxation

Barton puts the case for tax thus:

Deontologists can recognize a duty to care for the poor. The greatest of all deontologists, Immanuel Kant, certainly believed in duty to the poor, although he did not have a tax-funded welfare state in mind as a response. Thus anyone who uses a public hospital, or even a public road, should make sure that he or she pays tax to cover their use. He goes on to opine that Kant implied that a person who uses a facility, such as roads but evades paying the appropriate taxes, is essentially behaving like a thief, which would contravene one of the maxims.

¹⁷¹ Roff H M (2013) *Global Justice, Kant and the Responsibility to Protect*:

Essays on the Philosophy of Immanuel Kant Oxford University Press, 2007: ix–x.

<https://books.google.co.uk/books?isbn=1135105375>

Roff comments that

If a state is, as Kant says, a "moral person," then duties of justice towards the citizens of the state would be like having duties of justice to oneself.

¹⁷² Holland S (2007) *Public Health Ethics* p 20

<https://books.google.co.uk/books?isbn=074563303X>

Holland justifies the ethics of Public Health (as a State sponsored health system) for

Kant's moral theory is deontological because it is based on what he called 'the categorical imperative', i.e., the view that morality comprises a set of duties.

2.9 Consequentialism

Consequentialism looks at the outcome and judges the morality of the process, whether it is right or wrong by that. Its most famous advocates were Jeremy Bentham and John Stuart Mill.¹⁷³ In the forthcoming section I will use John Stewart Mill's utilitarianism, a form of consequentialism, which is based on the assumption that the ultimate aim of human activity is happiness in one sense or another. It will deal with the probable or possible consequences¹⁷⁴ of psychoactive drug taking for recreational purposes and the effects that might have for a person, their family, society and the State.

John Stewart Mill's states that a person, of sound mind has full and sovereign rights over himself. Whatever a man does to himself is his business, even if society regards his actions with 'disapprobation'. Society, the State that is, has no right to infringe the person's privacy or liberty, which sentiment is strongly supported by Szasz, who maintains that:

*Genuine commitment to the ethic of personal freedom and responsibility requires that, much as we may disapprove of a person's choice of drug, we must regard freedom of self-medication as a fundamental right.*¹⁷⁵

Mill uses the example of drunkenness; even if a man is drunk, it is still his own affair. For the example of addiction to alcohol, one may use equally well that of drug taking and intoxication.

Mill proposes that a person ought not to be punished simply for being drunk; that is his own business. Even a soldier or a policeman should not be punished for being drunk on duty; the punishment should come because the man is in Breach of Duty, which is the result of the drunkenness, but not for the drunkenness itself.

But whenever, there is definite damage, or a clearly identifiable and preventable risk of harm, to the public, then as Mill puts it: 'he may be deservedly reprobated or punished'.

Thus what a person does to himself is his business¹⁷⁶ as long as it doesn't harm other people (*Mill's Harm Principle*), yet there may be but few circumstances in which a person's self-determination affects no-one but themselves. Thus a reasonable person might always contemplate what effect their own actions might be having on people round about.

John Donne put it thus:

*'No man is an island,entire of itself,
Every man is a piece of the continent,
'A part of the main...'*¹⁷⁷

Drug Free Australia¹⁷⁸ puts Donne's sentiments into a modern context arguing that:

'The notion that illicit drug use is a victimless crime and that everyone should be free to do what they like with their body disregards the web of social interactions that constitute human existence. Affected by an individual's illicit drug use are children, parents, grandparents, friends, colleagues, work, victims of drugged drivers, crime victims, elder abuse, sexual victims etc. Illicit drug used is no less victimless than alcoholism'

¹⁷³ Warburton N (1992) Jeremy Bentham(1748-1832) & John Stuart Mill(1806-73) in *Philosophy Consequentialism* p46 et seq Routledge 5th ed

¹⁷⁴ Warburton N (1992) *ibid* p 47

¹⁷⁵ Szasz T S (1971) *The Ethics of Addiction* page 541. *Amer.J.Psych.* 128:5,November 1971

I am grateful to my tutor Dr Anna Smajdor for drawing my attention to this paper.

¹⁷⁶ Mill J S in Warburton N (1992) *ibid* p 90 'unless they are harming someone else or are mentally incompetent.'

¹⁷⁷ Wikipedia. John Donne (1572-1631) *No man is an island.....*
en.wikipedia.org/wiki/John_Donne

¹⁷⁸ Drug Free Australia (2009) *Arguments for Prohibition and against legalisation* p7
www.drugfree.org.au/.../Taskforce_Arguments_for_Prohibition.pdf

Mill himself observed that

‘No person is an entirely isolated being; it is impossible for a person to do anything seriously or permanently hurtful to himself, without mischief reaching at least to his near connections, and often far beyond them.’¹⁷⁹

This is where the Millian harm principle weakens: the drug taker does not harm others unless he becomes addicted. Even then an addict may remain symptom free, in their usual work and maintaining normal relations with family and friends; indeed as discussed above their work and life may be enhanced. But if the user is found in possession by the police they may be arrested and charged with a crime *where there is no victim*.

If the user does become addicted or develops symptomatic impairment of their life then he could be said to have become a victim of his own folly. But more certainly they render their family victims through deprivation of the normally expected life style.

If a person deep in addiction is unable to make rational choices and not now leading the life they would have wanted to be living, then the boundaries of Mill’s principles have been reached.

The question then is how to decide when a person has reached that point and whether the ability to think rationally has been lost. Philosophically one might say that the rational person derives their opinions and ideas through reasoning based on facts and logical thinking. If a person is acting irrationally they may be basing their opinions on emotions to the exclusion of logical thought. However both emotions and logical thought are open to definition; an emotion has subjective value and logical thought by contrast might be considered objective. The rational person would probably balance both in their mind in coming to a decision. Then the person who might be the recipient or object of the other’s decision would be expected to have similar thought processes, and engage in an interaction with the other as a result. It would be a delicate transaction, perhaps depending in a large part on subliminal messages between the two people.

2.9.1 Negative Utilitarianism

Mill’s utilitarianism is based upon the concept of attaining the most happiness that may be attained. Negative utilitarianism is the concept of attaining the least amount of unhappiness. If a thousand people are enjoying a rave, with their enjoyment enhanced through the use of Ecstasy, and one falls ill, how is one to measure the overall morality?

There is a clear consequentialist utilitarian ethic here; if the purpose of life is to attain the greatest happiness, and the least unhappiness, then harm reduction fulfils that ethic completely, and anything which contributes to that is to be welcomed. That will be dealt with fully in the Chapter on decriminalisation and legalisation.

To summarise: a consequentialist assessment of psychoactive drug taking is that the user, if adult and fully autonomous, may exercise freedom over themselves and to take drugs if that is their wish; providing that others are not harmed as result.

If, on the other hand, the user’s faculties become impaired as a result of addiction, and they lose their full autonomous self-determination and rationality, then they may have to be helped by their medical advisor or others.

Furthermore if the drug user develops secondary conditions as a result of the habit, causing harm or financial stress to family or to society, the introduction of harm reducing measures is fully justified by the ethics of consequentialism.

¹⁷⁹ Mill J S (1806-73) On Liberty Chapter IV *Of the Limits to the Authority of Society over the Individual*
www.bartleby.com/130/

2.10 Virtue Ethics and Drug Taking

Virtue Ethics is concerned with the character of the person being discussed, and this was first described in the way the term is used today by Aristotle in the 5th Century BC.

Aristotle¹⁸⁰ said that the right act was that which was a virtuous person would do under the pertaining circumstances, and the virtuous person would show those characteristics. They might be inherent in a man's or woman's personality or could be learned or gained by experience. Thus Aristotelian virtues would have been shown by the Good Samaritan¹⁸¹ in giving succour to the injured traveller.

This Chapter will use virtue ethics to examine psychoactive recreational drug taking, from the perspective of the user, their next-of-kin¹⁸² and the State (GP or medical advisor).

Is there virtue or vice in drug taking or is it an illness?¹⁸³ President Nixon in his 'War on Drugs' stated:

*'This Administration has declared all-out global war on the drug menace.'*¹⁸⁴

clearly regarding it as a vice, as many churchmen and others have thought and still do. The intellectuals of the Enlightenment presumably thought otherwise, as I have outlined in the history part of this dissertation, for they were virtuously enhancing the beauty of the world.

One of the problems of using 'virtue' in ethics is the problem of defining what is meant; which patterns of behaviour, desire and feeling are to count as virtues¹⁸⁵. The ethical understanding of virtue is a changing pattern of thoughts, beliefs and prejudices, and are not sufficient in themselves to influence an outcome. Perhaps one should say that using recreational drugs is usually virtuous but once a person is addicted it becomes a vice. If the Aristotelian concept of *Eudaimonia* is the apogee of fulfillment, is that what the raver high on LSD is feeling? Was that my sensation when I heard Faure's Requiem for the first time?

The Christian Virtues as described in the Bible are 'Faith, Hope and Love'¹⁸⁶. Perhaps a modern interpretation might be a person's attitude of mind to a situation or to another person. It is indeed noteworthy that one of the most important virtues of a doctor to his patient is 'Compassion', missing from the lists of Homeric or Aristotelian Virtues as it is absent in the Hippocratic Oath.¹⁸⁷ (p)

Virtue as such was first described by Homer (born circa 850BC) as life became more civilized people and developed code of conduct. The Homeric Virtues¹⁸⁸ are

¹⁸⁰ Aristotle in Warburton N (1992) *Philosophy* p53 et seq

¹⁸¹ The Holy Bible; Gospel According to St Luke Chapter 10 vv29-35 *The parable of the Good Samaritan*

¹⁸² See footnote 156 which gives a full description of how this is defined

¹⁸³ Fieser J (2008) *Drugs (The practice of Morality)* from Moral Issues that Divide Us and Applied Ethics www.utm.edu/staff/jfieser/class 'some people consider addiction to be moral matter others a matter of disease. Thus the moral model implies the person to have sufficient will power or lack of it to overcome or succumb to addiction. In other words virtue or vice and that is the rationale of the concept of 'sinful' behaviour. Others believe that addiction is a disease/ or mental impairment related to underlying factors' as described in Chapter 1 pp2&3

¹⁸⁴ Guardian Newspaper 23 July 2011 "America's public enemy number one in the United States is drug abuse," Nixon declared in a June 17, 1971 press conference. "In order to fight and defeat this enemy, it is necessary to wage a new, all-out offensive." Just two years later he escalated his rhetoric yet again, asserting that "this Administration has declared all-out, global war on the drug menace,"

¹⁸⁵ Warburton N (1992) *ibid* p 54

¹⁸⁶ Holy Bible 1 Corinthians Ch13 vv8-13

¹⁸⁷ Hippocratic Oath see Annex A(p)

¹⁸⁸ Rosenthal Joel H. 27 March 2012 *Ethics and War in Homer's Iliad* www.carnegiecouncil.org/publications/articles_papers.../0125.html

<i>Courage</i>	
<i>Friendship</i>	
<i>Justice:</i>	<i>retributive justice (getting what you deserve)</i> <i>distributive justice (making sure that the goods of society are distributed fairly)</i>
<i>Wisdom</i>	

Table 11 Homer's Virtues

Source Rosenthal J H

Aristotle codified virtues in two sets,¹⁸⁹ the intellectual virtues which a person learns and the moral virtues which are gained through habit and experience.

The nine Intellectual Virtues		
Art or technical skill (<i>techne</i>)	The five primary virtues	
Scientific knowledge (<i>episteme</i>)		
Prudence or practical wisdom (<i>phronesis</i>)		
Intelligence or intuition (<i>nous</i>)		
Wisdom (<i>sophia</i>)		
Resourcefulness & deliberation(<i>eubolia</i>)	The four secondary intellectual virtues	
Understanding (<i>sunesis</i>)		
Judgment (<i>gnome</i>)		
Cleverness (<i>deinotes</i>)		
The twelve moral virtues with their corresponding vices		
Vice of deficiency	Virtue	Vice of excess
Cowardice	Courage	Rashness
Insensibility	Temperance	Intemperance
Illiberality	Liberality	Prodigality
Pettiness	Munificence	Vulgarity
Humble-mindedness	High-mindedness	Vain gloriousness
Lack of ambition	Right ambition	Over ambition
Spiritlessness	Good temper	Irascibility
Surliness	Friendliness &Civility	Obsequiousness
Sarcasm	Sincerity	Boastfulness
Boorishness	Wittiness	Buffoonery
Shamelessness	Modesty	Bashfulness
Callousness	Just resentment	Spitefulness

Table 12 Aristotle's code of Vices and Virtues

Courtesy of the Society of Apothecaries

Virtue Theorists focus on character and are interested in the individual's life as a whole, with the central question being 'how should I live?' The answer is to cultivate the virtues in order to flourish in a virtuous life.¹⁹⁰ However the value of a virtue may depend upon circumstances. Thus a warrior might value 'Courage' highly, and consider 'Humility' not a virtue at all. For the tabloid press anything to do with psychoactive drug taking is considered as being a vice. If a politician tries to explore the possibility of an alternative to 'Prohibition' as a possible approach to the problem of drug

¹⁸⁹ Misselbrook D (2013) *DPMSA 2013 course lecture notes. Courtesy of the Society of Apothecaries of London* ibid *Lecture on Virtue Ethics*

¹⁹⁰ Warburton N (1992) ibid p53

abuse, he or she may be castigated as being ‘soft on drugs’ that is feeble and lacking in virtue¹⁹¹. When Norman Fowler, then the Minister of Health ¹⁹², introduced the ‘clean needle scheme’ in 1986, was he acting deontologically with a sense of duty, or consequentially foreseeing the outcome of what was being proposed, or virtuously feeling compassion for those people stricken by HIV and Hepatitis, or courageously in taking a measure which was not popular with the Press or with his Prime Minister, Mrs. Thatcher? The answer may well be to have been all three.

2.10.1 Virtue Ethics and the Drug User

Virtue ethics applied to drug taking, can be considered either as applying to the drug user, to their ‘neighbour’ or to their medical advisor or to State (in the form of the Public Health services), and each of these will be examined in turn.

Let us deal with the morality of the user first. A person uses drugs for different reasons: it gives pleasure, it is calming, provides solace or creativity is enhanced; maybe the user enjoys the hallucinations or the feeling of invincibility or of being closer to God. Psychoactive substances have many effects as has been outlined in Chapter 1. They all have the risk however of causing dependence and then addiction.

To the casual user, which is the majority, ethical matters would be unlikely to come into consideration. The casual user probably feels virtuous about it for they feel good taking the drug; it is unlikely that they would feel they are indulging in a vice. At the most the casual user might feel perhaps they shouldn’t be doing it, but the enjoyment gained is worth the risk. Most people would open a bottle of champagne to celebrate and not think ethically of the risk that there *might just* be someone there who *might* thereby be started on the path to alcoholism¹⁹³.

Similarly the drug user would have to show virtues¹⁹⁴: *wisdom* to consider whether it would be better not to start at all. *Temperance* that is use in moderation if they are not to overindulge in taking it and sliding into drug dependence. Again they would need to show *wisdom* not to let their enjoyment of the drug interfere with their daily activities, their family life etc. Also *wisdom* would be needed to refrain from taking ‘hard drugs’(heroin, cocaine, amphetamine) and staying with the ‘soft ones.’(cannabis, LSD and Ecstasy). The drug user also needs to show the *courage* of self-discipline and making themselves control their indulgence and not become an addict.

If the recreational user does become addicted they need the virtues of *wisdom* and *courage* to seek help, and *trust* in those who are coming to the rescue. They should accept with *humility* the need to do something about the addiction, and the fact that their family and friends might be suffering.

¹⁹¹ See Chapter 4 where newspapers are quoted with views such as: ‘we need legalisation (of drugs) like a hole in the head’ (2011) to ‘A tide of support for legalisation seems to be rising around the world. Could it work here too?’ (2014)

¹⁹² Fowler N 1991 *Ministers Decide: A Personal Memoir of the Thatcher Years* Chapman, London (City Library Norwich) In reading his memoirs it is clear that Mr. (now Lord) Fowler was indeed moved to compassion for HIV sufferers, thought the matter through with his specialist advisors, and took the right, and at the time unpopular measures, which have been shown to have been so correct. The HIV rate for injecting drug users in the UK is amongst the lowest in Europe. Many people have cause to be grateful to him!

¹⁹³ If, of course, you know that one of your friends is a recovered alcoholic or has an alcohol related illness, you would act virtuously in having an alcohol free drink available. You would not be acting virtuously in persuading a person to drink who didn’t want to, and it would be even worse to try to persuade an under-age child to drink.

¹⁹⁴ Pigliucci M (2011) *Rationally Speaking: On ethics, part IV: Virtue ethics* rationallyspeaking.blogspot.com/.../on-ethics-part-iv-virtue-ethics.html

If the drug addict's friends are also drug addicts maybe they are happier in remaining so, and the health authorities' efforts would be unwanted officiousness. It was mentioned above that some people take drugs for solace; their lives may be so miserable that to dream away the days with drugs may be a better life than being fully alert and aware of the world around. A doctor may be more compassionate in allowing the old druggie to while away their time rather than trying to coerce them into good health again.

Does the person who had sunk into a life of addiction, thieving and vice, yet recovers to lead a good life warrant being considered more virtuous than the person who has been always good? Is it on balance better to be a sinner reformed and overcomes that, to regain a life of virtue,¹⁹⁵ deserve more credit than the person never to have sinned at all? The Bible thinks so.¹⁹⁶ The answer might depend on whether the quantum of virtue lost could be measured against that gained, and the opinion of the person measuring that. A doctor perhaps would praise the patient who has given up smoking, but would not feel the requirement to comment to the person who had never smoked.

One might speculate that is it easier to remain virtuous than it is to regain virtue after having slipped into vice. Recidivism is a feature of drug addiction which has to be handled as a chronic disease, though some would disagree with that.¹⁹⁷ It could be said that such a person, who has repeatedly and virtuously to make the effort to overcome their addiction, is more to be admired than the person who has never had those problems.

2.10.2 Virtue Ethics and the Addict's Helpers *

The other side of the matter is the addict's helpers and the virtues they will need to display if they are to help the addict into recovery.

The addict's nearest and dearest need to show *love*, *compassion*, *good temper*, and perhaps other virtues such as *resourcefulness* and *skill* as well as *tact*, *diplomacy*, and *perseverance*. All these virtues the addict's medical adviser and counsellor and the other people they'll meet whilst undergoing treatment will need to have. In addition they will also need to demonstrate technical *skills*, scientific *knowledge* and *compassion*. All are required if the patient is to be properly cared for; above all they will need to have *trust* in the patient and will need to have the skill to be able to get the patient to trust them.

Not all people who are drug-dependent wish to have medical help. It is possible to function normally in the family and at work whilst taking large doses of heroin, as was shown in the Swiss Heroin Assisted Therapy trial**. However for Problematic Drug Users and Injecting Drug Users whether they wish to receive medical help or not, it is up to the Public Health Care that they do, as the figures given below show.¹⁹⁸ The level of acceptance of treatment is a measure of the success of drug health care; and as is shown in the footnote, the UK does not rate highly.

* by this is meant family members, neighbours, friends and relations

¹⁹⁵ Alcohol Rehab (2011) *The Importance of Humility in Recovery*
alcoholrehab.com ›

** see Chapter 4 (Switzerland)

¹⁹⁶ St Luke's Gospel Chapter 15 v7. 'I tell you that in the same way there will be more joy in heaven over one sinner who repents, ... over one sinner reforming, rather than over ninety-nine righteous men, who have never experienced his temptations.'

¹⁹⁷ Szasz T A (1971) *The ethics of addiction* Amer.J.Psychiat.128:5, November 1971 (in this article Professor Szasz emphatically rejects that addiction to drugs is a disease and makes the case that it is instead a moral problem) I am grateful to my tutor Dr Anna Smajdor for drawing my attention to this article.

¹⁹⁸ see Chapter 4 IDUs & PDUs %age in Treatment UK44.4 CR 90.6 Germany appx100 Netherlands appx 100%
Deaths/million UK38.4 CR 3.9 Germany 3.9 10.2

2.10.3 Virtue Ethics, Drugs and Society

Having considered the place of virtue ethics in relation to the drug user and that immediately in relationship with the user, consideration will now be given to how virtue ethics may influence the attitude of society towards the drug user.

What will be examined is the ethics of the Aristotelian mean between *Harm Reduction* and *Abstinence*; described by Christie et al(2008) as being exemplified by *Compassion*¹⁹⁹ for the drug addict. They defined compassion as the mean between the two extremes of being ‘*too hard*’, in not having enough sensitivity and ‘*too soft*’ in having too much sensitivity.

As this is a dissertation dealing with practical matters, not simply hypotheses, what might the public in practical measures do in demonstrating such compassion, and the other virtues needed to construct a drug health care policy and to get it carried out? This will now be explored.

What would be meant for practical purposes by acting virtuously in this context? The context in which to display the virtue is in doing the right thing, to the right people in the right way and for the right reasons. In other words all the professional facets which a public health physician would consider when approaching a medical problem, such as drug addiction in the population.

Thus the hard approach might mean insistence on abstinence as the only sensible aim, and doing away with harm reduction programmes such as needle exchange , supervised injection and so on, which lacks compassion. People die, transmit illnesses such as HIV and hepatitis; such an attitude could not be sustained .This was recognised early on in Switzerland (see Chapter 4).

It is virtuous to promote virtue and so compassionate programmes of harm reduction help people to rise from the vice of addiction to become virtuous persons again. Harm reduction programmes have been shown in this dissertation not to increase drug usage, but to make the ill citizens less so, to relieve suffering and so they are compassionate and morally valuable.

What *needs* to be done by society is the subject of Chapter 6: The Ideal Model Drug Policy. *How* to get it done is where the virtues have to be demonstrated.

Scientists have to have the pertinacity to persuade politicians, and politicians have to have the courage to raise their voices²⁰⁰&²⁰¹ and then have the tactical skill and wit to seize the opportunity to do something about the matter²⁰². However compassion is the underlying virtue which instigates all the others

So risk reduction by ensuring pure drugs, and harm reduction with clean needle availability for intravenous drug users, skin cleansers and a clean environment, health checks and treatment, ill-health prevention, counselling and informal advice about the addiction and how to reduce it; advice about other life-style matters and so on, all given in

¹⁹⁹ Christie T, Groarke L, Sweet W (2008) *Virtue ethics as an alternative to deontological and consequentialist ethics* Int J Drug Policy. 2008 Feb;19(1):52-8. doi: 10.1016/j.drugpo.2007.11.020. Epub 2008 Jan 15. www.ncbi.nlm.nih.gov/pubmed/18226518

²⁰⁰ House of Lords (2013) *Debate 17 October 2013* <http://www.publication.parliament.uk/pa/ldhansard/text/131017-00001.htm>

²⁰¹ House of Commons (2014) *Debate 30 October 2014* <http://www.publications.parliament.uk/pa/cm20145/cmhansard/cm141030/debtext/141030-0003.htm>

²⁰² Carey G & Crammond B (2015) *Action on the social determinants of health: Views from inside the policy process*. Social Science and Medicine 128 (2015) 134-141 (from Australian National University and Monash University Australia)

I am grateful to my tutor Dr Andrea Stockl for drawing my attention to this paper which describes not only *what* needs to be done if one is to change the social determinants of ill health, but *how* to do it.

a non-judgmental way, whilst showing compassion and understanding for the patient in all their vulnerability.

2.11 What is the morality of taking socially acceptable psychoactives?

All three of the normative theories may be used to answer the question whether there are moral problems with the other psychoactives which are socially acceptable: nicotine in smoking, caffeine in tea and coffee, or drinking alcohol.

Kant emphasized the moral right of an autonomous and rational person to the self-determination of their own destiny, coupled with respect for the autonomy of others. Such a person has a duty not to harm themselves or others. So moderate smoking, coffee and alcohol drinking would not be expected to contravene these dicta, unless the subject has an underlying illness, which would be exacerbated as a result. Thus it would be acceptable to drink coffee normally if one is healthy but immoral to do so if coronary artery disease is severe and might be worsened as a result. It would be immoral to press a drink upon a person knowing them to be a recovered alcoholic, in the knowledge that doing so might cause them to relapse.

The consequentialist would recognise the potential harm in the use of all psychoactive substances taken to excess; forty cigarettes a day for thirty years and there is a 50% chance of life threatening illness, which implies that amount of smoking is immoral, for it is causing self-harm.

Virtue theory would indicate impaired morality if one is overusing socially acceptable psychoactives. It would not be virtuous to become drunk or to annoy others with cigarette smoking in an enclosed area. Nor would it be virtuous to spend excessively on self gratification and deprive one's family as a result.

2.12 How does relativism complement the normative theories?

The question is how does relativism help a person in deciding how to act in a moral manner in a situation of drug addiction or potential drug addiction? Say a parent is trying to advise their teenage child not to take drugs, and the youngster is taking the moral relativist attitude that *they* know what is right, and that the oldies are out of date; or say that your brother/sister is, you suspect, taking drugs, and you know they think that it is alright to do so, yet you are certain that they are beginning to show signs of mental damage, then what is to be done?

The practicality of the matter is that young people may not be mature enough, or trained in philosophy, to be able to make up their minds wisely, and will take risks which the wiser adults would rather they did not. (Here, as will be later discussed, come the practical approaches of 'risk reduction'²⁰³ and harm reduction²⁰⁴ by Public Health measures which would probably not be accessible to the ordinary person.)

First one should respect their degree of autonomy and maturity and their ability to analyse the situation relatively. The parent should consider their own moral perspectives and values in this situation; remind themselves of the three philosophical analyses described, where their duty lies, and reflect on the potential and possible consequences, and act virtuously attempting to bring the subject out of what you think is a situation of

²⁰³ See Chapter 4 *the Dutch Health Minister assessed that young people would take drugs anyway and authorised soft drugs, cannabis, to be sold under regulated and controlled conditions in 'coffee shops', assuming that as a result they wouldn't be tempted by hard drugs. Which is exactly what happened.*

²⁰⁴ See Chapter 4 *In Holland for a rave to be authorised nowadays the local Town Council stipulates that the rave organisers have to provide facilities for drug testing (for Ecstasy especially, of which 'Martha' died) and a chilling out room (for rest and rehydration) for the ravers.*

wrongness into one which you consider to be right. Thus the parent would attempt to balance the objectivity of relativism with the values of their own judgement.

Sacks put this succinctly:

*We should challenge the relativism that tells us there is no right or wrong, when every instinct of our mind knows it is not so, and is a mere excuse to allow us to indulge in what we believe we can get away with. A world without values quickly becomes a world without value”*²⁰⁵

My personal position is essentially as Sacks put it. There is *right* as there is *wrong*, and the philosophers point us in the correct direction as does one’s religious background which will be mentioned below. Relativism is an additional tool in this, and imparts the sense of objectivity. Although I might know I am right, the possibility is always there that I might *not* be. Thus in coming to a decision one should have explored the relevant factors rationally and comprehensively.

2.13 Summary

At the beginning of this chapter I noted that the understanding of morality is changing as is the mood of the public about drug usage. Opinion polls, indicate that the number of people who would support amendment of the current drug policy is increasing annually, especially where it concerns the use of soft drugs such as cannabis.

The debate in the House of Commons showed an overwhelming support by the MPs who attended, *yet the vast majority was not there and did not express an opinion.*

Whether the newspapers may be considered to be a true litmus of public opinion is questionable. Those that were against change of drug policy in the past still appear to be so now; admittedly not so vociferously as there were though. In some reports proposed alterations of the law are being supported.

My feeling is that there is a general coming round in public opinion and that after the election, and when the UN have had their session in 2016, drug policy in the UK will start to change; the window of change which Gemma and Crammond remarked on may soon open.

Next the morality of taking illegal drugs was examined. The place of relativism was established and then the three normative ethical theories used as instruments to examine this matter and to seek to provide some guidance. Kant’s deontology, virtue ethics and consequentialism pointed to the possible solutions. They are not contradictory but complement each other with their different approaches, for there is no simple answer.

It is a mosaic of images: the rights and duties of the user, of the immediate ‘neighbour’, family and friends, of the State and of the person’s medical advisor. It is morally acceptable that a rational person has the right to do what they like with themselves and take risks, but have a duty not to harm themselves, or others in what they do. Thus it is not immoral to take drugs, but it may be foolish, for the user might become dependent. It would be virtuous to keep a rein on what one is doing and to seek help if one cannot help oneself.

The drug user’s friends and family have a duty to help the user avoid slipping into addiction. The medical adviser has a duty to their patient to act appropriately and paternalistically if their medical experience indicates the need for that. Public health and

²⁰⁵ Sacks J (2002) *The Dignity of Difference* (Lord Sacks was a past Professor at the Hebrew University in Jerusalem and a past Chief Rabbi of the Commonwealth)
www.goodreads.com/author/quotes/55332.Jonathan_Sacks

the State has the duty to educate young people appropriately and to do what is necessary to reduce risk and harm both to people who are rational and to people who are not, those underage or lacking the capacity of comprehension. For those who have become drug dependent the addict's family and friends, medical adviser and the State have to act compassionately with programmes of harm reduction.

My opinion is that this analysis clearly shows the taking of psychoactive drugs is acceptable for a rational and fully competent adult. Yet they have to accept the fact that the drug may lead to addiction and a user ought to consider the risk of that. A rational person should act responsibly with themselves and towards others at all times.

Although a person has the right to take drugs it would be wise of them to contemplate whether it might be better if they didn't start.

Chapter 3. The arguments for and against Prohibition

3.1 Introduction

According to Barnett (2009) a Drugs Policy formulated upon prohibition is based on a mistaken analysis of the law of supply and demand. If you reduce supply of a 'normal' commodity, the demand will reduce because people will either do without or use something else. But as Barnett pointed out where illegal drugs are concerned, which people who are addicted cannot do without, demand does not fall; on the contrary prices rise and thieving increases,²⁰⁶ or the drugs are taken in another more efficient way (instead of smoking, injecting with resulting increase of infection)²⁰⁷, or the drugs are adulterated (cutting), or users switch to newer drugs (to NPS²⁰⁸ and neither the users nor emergency doctors know how they work). The underground market for illegal drugs and criminal thrives²⁰⁹, as do the police, legal, and prison services.

However those who initiated prohibition had their reasons for doing it and this chapter examines the arguments for and against prohibition, taking into account the present situation and the consequences of the previous policies. These arguments will lead into a fuller examination in the ensuing chapters on legalisation and decriminalisation; there will be analysed the drug policies and their outcomes in Portugal, the Netherlands, Switzerland, Germany and the Czech Republic. These have been selected for they all have good outcomes compared with those of the United Kingdom.

3.2 Background

In 2011 the UN Global Commission on Drug Policy stated:

*'the global war on drugs has failed with devastating consequences for individuals and societies around the world...fundamental reforms in national and global drug control policies are urgently needed'*²¹⁰

At a meeting with world leaders which included Kofi Anna, past Secretary General of the United Nations, it was resolved that a Special Session would be held in 2016, for the purpose of resolving the problem.²¹¹

The quotation shows how the mood and the perceptions of the international leaders have changed over the past century.

However the key question to be asked is what should be the aim of a policy on psychoactive recreational drugs? Should it be prohibition and legislation to try to prevent

²⁰⁶Barnett R E (2009) *The Harmful Side Effects of Drug Prohibition* (Georgetown Law and Legal Theory Research Paper No 12-037) pp18&19 *Drug Laws Raise the Price of Drugs to Users*
<http://scholarship.law.georgetown.edu/facpub/817>

²⁰⁷Barnett R E (2009) *ibid* at page 19 footnote 28 Professor Barnett comments:
For instance, in Hong Kong until recently, heroin, though illegal, was cheap and relatively available, and the drug was inhaled in smoke rather than injected. In the last few years, however, law enforcement has been able to exert pressure on the supply of the drug, raising its price considerably and resulting in a significant increase in the use of injection.

²⁰⁸ NPS: new or novel psychoactive substances

²⁰⁹ Barnett R E (2009)*ibid* p19 *Drug Laws Make Drug Users Buy from Criminals*

²¹⁰ UN Drug Control (2011)*Global Commission on Drug Policy Report* -
www.undrugcontrol.info/.../un-drug.../2413-global-commission-on-drug...

²¹¹United Nations Drug Control (2011) *2016 United Nations General Assembly Special Session*
www.undrugcontrol.info/en/home/tag/109-2016-ungass

the availability and use of them? Or should it be focussed upon public health to reduce the medical and social risks and harms caused by psychoactive drugs. This chapter examines the arguments for and against prohibition and the legislation which is required to enforce it. Firstly the ethics of prohibition will be examined.

3.3 The Ethics of Prohibition

The ethical understanding of Prohibition has changed, as the quotations show. The approach used to be deontological, (and still is in some countries, such as the USA and Sweden) where the motive of prohibition and achieving a 'drug free world' was seen as more important than what *was actually* being accomplished.²¹² As a result prohibition was implemented across the world, although it became clear to some people that it was not working well: production and consumption of illegal drugs increased, disease spread and the death toll rose. Worse was that the banning of drugs gave rise to a flourishing black market with widespread corruption, and the formation of gangs and cartels with political destabilisation of some countries²¹³. It was perhaps naïve to imagine that simply impeding the supply through policing and legal sanctions would stop the problem. 'Zero tolerance' had failed, and it was time to undertake practical measures.²¹⁴

The failure of this deontological approach resulted in a gradual assumption of a consequentialist morality in drug policy, that is beneficial outcomes were to be sought. If a problem cannot be stopped at the outset it is morally correct to try to do something to ameliorate the effects of it.

The precipitating factor in several countries was the sudden spread of HIV and hepatitis among injecting drug users. Mino & Arsever of Switzerland movingly expressed how they realised they had betrayed their medical ethics up to that point.²¹⁵ The introduction of the 'clean needle scheme' stopped this and the concept of harm reduction began to be understood²¹⁶. The UK was one of the countries leading in this and now has an HIV rate amongst the lowest in Europe.²¹⁷

Risk reduction was also introduced in some countries; in the 1970's the Minister of Health of the Netherlands²¹⁸, convinced that young people were going to use cannabis whatever the law said, ordered the police not to prosecute hash smoking in clubs and 'coffee-shops', but, on the contrary, bear down heavily on 'hard drug' trafficking in the streets. The result has been that Holland has one of the lowest hard drug usage rates and deaths from drugs rates in Europe.

²¹² Wodak A, (2007) *Ethics and Drug Policy* from Transform Drug Policy Foundation
transform-drugs.blogspot.com/2007/02

²¹³ BBC TV (2015) *This World Secrets of Mexico's Drug War*
a dramatic depiction of Mexico's Sinaloa Drug Cartel widely regarded as the most powerful organised crime gang in the world; a multibillion-dollar international corporation with franchises in 58 countries (Radio Times 11th March 2015 p 94) The programme commented on the death rate of over 100,000 people and the widespread corruption in political and police circles in Mexico and the USA.

²¹⁴ Savalescu J & Foddy B (2012) *A moral argument against the war on drugs* from Practical Ethics
practicaethics.ox.uk/.../a-moral-argument-against-the-war-on-drugs

²¹⁵ Mino Annie, Arsever Sylvie (1996) *J'accuse les mensonges qui tuent les drogues*
Calmann-Levy, Rouen 1 Jan 1996
www.anpaa83.asso.fr/fiche_livre.php?compteur=1 see Chapter 4

²¹⁶ *In the USA by contrast it was thought that provision of clean needles would encourage drug use and give the 'wrong message'. Although this policy has now been reversed, the United States have one of the highest HIV rates in the Western World.* (see Chapter 4 page 3 footnote 8)

²¹⁷ National AIDS Trust (2013) *HIV and Injecting Drug Use*
www.nat.org.uk/.../HIV_and_Injecting_Drug_Use_Report_2013.pdf

²¹⁸ see Chapter 4

In some countries recreational drugs are checked for purity before the user enters the dance hall.²¹⁹ Government controlled purity checking of such drugs before they enter circulation is nowhere the case, as far as it is known though it has been proposed.²²⁰

Prohibition is not morally justified, for it is the state's infringement of the rights of an individual in their own life. However if it is the ideological belief of society that something is morally wrong, then some people might want something done about it.²²¹ Conforming to the beliefs of the society a person is used to, is part of maintaining the 'culture' of that society. Beckley put it thus

*The difficulty ... lies in the fact that it (the war against drugs) is an ideological war, and therefore is phrased in terms of a never-ending battle between the perceived forces of good and evil.*²²²

If then it is thought that the evil is a vice and will affect others, then the public may feel the need to fight or strive to have protection from it and for each other. Such thinking might well have been behind the Temperance Movement, which felt the need to proselytise its views against the evil immorality of alcohol and drugs²²³.

However it was John Stuart Mill²²⁴ who, in the time of intolerant puritan fanaticism, emphasised the state did *not* have the right to interfere in the moral attitudes of the individual.

Now the perception of morality is changing; the ideology of wickedness condemned by el Guindy in 1925 is being questioned in many countries. Uruguay has completely decriminalised recreational drugs in contravention of the UN directions²²⁵ and other countries are circumventing the rules in different ways.²²⁶

A parallel might be drawn with the changing moral understanding of homo-sexuality, as it was perceived in Britain and described in the previous chapter.^{227 228 229 230}

The argument against prohibition is that it is unethical, for it implies the State 'knows best'²³¹ and has a right to infringe a person's liberty even if the subject is a rational

²¹⁹ *These countries are Holland, where it is a condition of permission to hold a rave to have a testing bay available, and in Germany, Switzerland and the Czech Republic.(see Chapter 4).Such a testing facility has recently started in the UK as well.*

²²⁰ See Chapter 4

²²¹ Except for liberals or normative relativists who would consider that what other people do is none of their business

²²² Beckley Foundation(2015) Global Initiative for Drug Policy Reform *Drug Control* reformdrugpolicy.com/beckley-main-content/drug-control/

²²³ Encyclopaedia Britannica(2014) *Temperance Movement Social History* Britannia.com/EBchecked/topic/58630/temperance-movement

²²⁴ Mill John Stuart(1859) *On Liberty* p 68 Penguin Books 1974

²²⁵ Cataldi M & Llambias F (2013)*Uruguay becomes first country to legalize marijuana trade ...* www.reuters.com/.../us-uruguay-marijuana-vote-idUSBRE9BA0152013...(Reuters 10 Dec 013)

²²⁶ for example the drug policies of Portugal, the Netherlands, Switzerland, Germany and the Czech Republic which are all examined in Chapter 4

²²⁷ Dworkin R M (1966) *Lord Devlin and the Enforcement of Morals* - Yale Law School digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=4612...fss..

²²⁸ Notes on the Devlin-Hart Debate faculty.ypc.edu/~dweiss/phl347.../devlin%20and%20hart%20notes.pdf ill 8 M John Stuart(1859) *On Liberty* p 68 Penguin Books 1974

²²⁹ The Cabinet Papers(1957) *Homosexuality – The Wolfenden Report* www.nationalarchives.gov.uk › ... › Law, liberty and society *Lord Wolfenden chaired the Committee which recommended that adult homosexuality be legalised and condemned the criminalisation of homosexual acts*

²³⁰ House of Commons (1976) *Sexual Offences (Amendment) Act 1976* www.legislation.gov.uk/ukpga/1976/82/section/1

person, and has sovereign rights over their own body. That would be unacceptable paternalism by most ethicists. A citizen's freedom and autonomy is reduced if they are told what they should do with themselves, if not harming anyone else with what they are doing. As shown in Chapter 2, the addiction rate for most psychoactive drugs is below 20%. Thus prohibition is unethical for the vast majority of users, who are not even harming themselves but of course *might*. Unless it is accepted that it is the duty of the State to infringe a person's rights through coercion and the law from *possibly* harming themselves²³², to gain greater justice for society which might be harmed through the addict's condition or through having to pay treatment which might become necessary.

Public Health Medicine, through the law, has now acted paternalistically by banning smoking in public places,²³³ by getting cigarette packets to be made unattractive and with serious health warnings. Public Health Medicine also acted in such areas as seatbelt and crash helmet usage in the interests of preventing serious and life-threatening illnesses. In the Dissertation, *Thalassaemia Prevented...but was it ethical?*²³⁴ I made the case that it was consequentially acceptable to infringe the ethical right of self determination *a little bit*, if the *great potential gain* of avoiding the birth of a fatally disabled baby was to be achieved.²³⁵

In conclusion it can be said that prohibition, and the law which supports it, is *unethical*, for it infringes the right of self determination. This erosion of liberty could be avoided if the matter were taken from the legal system and given to Public Health Medicine to bring about risk and harm reduction. It can provide the health education, and health promotion necessary to allow people to make up their own minds and decide whether or not the better thing to do is not to embark on taking psychoactive drugs. This is deontologically sound too, for the increase in knowledge enhances a person's autonomy. On the other hand it may be considered acceptable that legal coercion is ethical in deterring people from taking up drug taking. This will be explored later.

3.4 Prohibition and the Law

The Convention of 1925 was followed in 1961 by almost all Nation States agreeing to introduce laws against the production, transport, storage, distribution and use of psychoactive drugs used for recreational purposes. The Misuse of Drugs Act 1971, the

²³¹ House of Commons publications (2006) Science and Technology Select Committee Report of 2006
Drug classification: making a hash of it?

www.publications.parliament.uk/pa/.../cmsselect/cmsstech/1031/1031.pdf

The Committee stated that whereas the report noted that legal enforcement underpins the government's policy on illegal drugs, the Committee found 'no solid evidence to support a deterrent effect'. The Committee found significant anomalies in the ABC classification system and concern at the harm to potential users and to society at large'.

The response from the Government was to acknowledge the lack of evidence, but said it fundamentally believes that risk-taking should be made illegal and that evidence will be found in due course to prove it. This could be believed to be similar to divine inspiration or as Mark Twain said: "Never let the facts get into the way of a good story."

²³² BMA Board of Science 2012 *Drugs of Dependence* BMA Publications Chapter 6 *Controlling Illicit Drug Use* p 98 and Chapter 11 *The role of medical professionals* p185 ISBN 13:978-1-905545-67-4

²³³ See Annex A(o) for a discussion on paternalism

²³⁴ Forsythe-Yorke W (2013) *Thalassaemia Prevented...but was it ethical?* Dissertation for the Diploma in the Philosophy and Ethics of Medicine of the Society of Apothecaries.

²³⁵ *During the research for this project, I consulted the Archimandrite of the Greek Orthodox Church in London, for the subject of my research lay in Cyprus, where that faith predominates. I learned from him that it would be considered to be a greater sin to give birth to a baby, knowing beforehand that it would have a life so terribly disabled as to be not worth living, than it would be to have the pregnancy terminated.*

updated version of the law which was introduced in the UK to implement the Convention, states that it is illegal to possess a controlled substance²³⁶ unlawfully, supply or give it to others or use premises for that purpose of producing or using it. So legislation was introduced to enforce the Act.

Laws in the UK can be divided into two groups²³⁷ ‘*malum in se*’, wrong-in-itself laws and ‘*malum prohibitum*’, wrong-by-statute laws. The first usually involves violence and the wrong is generally not controversial. The criminal is the subject in the crime, and deserves to be punished. The victim, who has been harmed in the criminal act is the object and is to be helped or compensated. By contrast laws-by-statute are made because society for ideological, religious or moral reasons deems an action to be unlawful, and have enacted laws to enforce that opinion²³⁸. The laws are often controversial, may be hard to justify, and are ‘unstable’ that is to say they are liable to change. The changing perception of homosexuality already has been mentioned; same sex marriage is another example. The changing morality of recreational psychoactive drug use exemplifies the difficulty of maintaining these laws-by-statute.

In the case of a drug use offence the perpetrator of the offence, the user, is the subject of the offence, because they have broken the law. Who then is the object of the offence? Whom has the villain harmed, but *themselves*? It is the same person, and surely they as the victim do not warrant punishment but rather help and support; for they are the victim of their own moral weakness no more, and are suffering their own punishment through becoming addicted.²³⁹ If the subject and the object of the crime is the same person, it seems difficult to justify legal procedures against them, as used to be the law on suicide.(Chapter2.)

Thus it appears to be the case that not only Prohibition is unethical, that it is morally wrong, it then follows that the Legislation installed to enforce it is also morally wrong. Although of course it became legal because it was enacted by Parliament in the Misuse of Drugs Act 1971.²⁴⁰

If the Law is transgressed, punishment with the removal of freedom follows. Punishment by the State has been justified philosophically in four ways *retribution, deterrence, protection of society and reform of the person punished*²⁴¹, and these be examined later. However enforcement usually starts when there is suspicion that a person possesses illegal drugs. They are usually searched either on the street: ‘stopped-and-searched’ or their accommodation is searched, and the effectiveness of that aspect of Prohibition, having profound and unexpected effects upon society, will be examined next for it is usually the first contact that a user will have with the law.

²³⁶ *Controlled Substance: this term comprises street drugs of abuse, and medicinal drugs which could be used illegally. For example the opiate Methadone used in treating heroin addiction, is sometimes ‘sold on’ in the street by addicts who have a little to spare.*

²³⁷ Jacobs P (2014) personal communication (see Annex C acknowledgements).

²³⁸ *In the past Faith used to be the determining factor. If a person did not agree the predominating version of the Christian faith they might be burned at the stake as heretic. Today a Muslim who does not believe is deemed an apostate the penalty for which is death.*

see Islamqa.info Why is the apostate to be executed in Islam?

islamqa.info > ... > Punishment and Judicial Sentences

²³⁹ Barratt R(2009) *ibid* page 18

²⁴⁰ Parliament UK (1971) *Misuse of Drugs Act 1971* Legislation.gov.uk
www.legislation.gov.uk/ukpga/1971/38/contents

²⁴¹ Home Office (1990) *Crime, Justice and Protecting the Public* White Paper Government’s proposal for legislation

3.4.1 Stops-and-searches

In 1986 the number of drug-related stops-and-searches in the UK was 32,500 and arrests 6,200. In 2006/7 there were 406,500 stops-and-searches and 33,000 arrests.²⁴² Total stops-and-searches (for all reasons) in 2013 were 1,100,000 with 9% arrests. *Ethnic black people outnumbered white 6:1 and Asians to whites were 2:1*, in stops-and-searches, and blacks were significantly more likely to be committed to prison and then for longer sentences than white people. Stevens noted that there is no clear reason apparent to him for the apparent ethnic discrimination,²⁴³ and that rates of possession are almost the same in all ethnic groups²⁴⁴.

White/Black disproportion with drug offences are shown in the following graph and whatever the reason, the ethnic discrimination led to significant disharmony with the police and the seemingly biased stops-and--searches may well have contributed to the Brixton race riots of 2011.²⁴⁵ The ethnic imbalance is shown in the following bar chart:

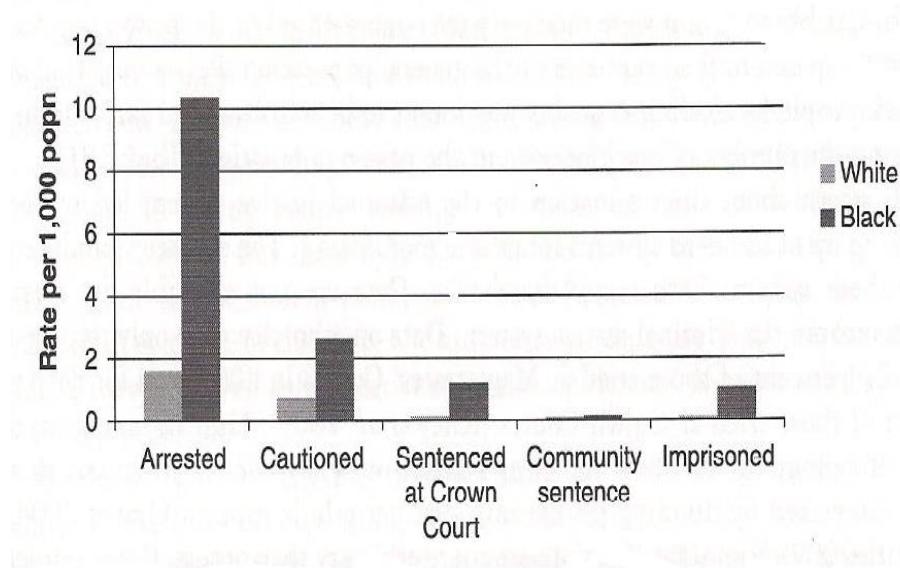


Table 13 Proportion of white and black people in the criminal justice system for drug offences in England and Wales 2007/8

Source Stevens A (2011) *Drugs, Crime and Public Health* p96

Black people were 28 times more likely to be stopped and searched than white people, six times more likely to be arrested and 11.4 times more likely to be jailed.²⁴⁶ ²⁴⁷This high

²⁴²van Beuren G & Woolley S (2011) *Stop and think: a critical review of the use of stop and search powers in England and Wales* - Equality and Human Rights Commission.
www.equalityhumanrights.com/sites/default/.../stop_and_think_again.pdf

²⁴³Stevens A (2011) *ibid* p 98 *Race, racism and inequality*

²⁴⁴Stevens A (2011) *ibid* p 97 *Ethnic disparities in drug law enforcement*

²⁴⁵Prasad R (2011) *Reading the Riots: 'Humiliating' stop and search a key factor*. (Guardian Newspaper 6 Dec 11)

²⁴⁶Dodd V (2011) *Guardian Newspaper Police up to 28 times more likely to stop and search black men; black people six times more likely to face drug arrest.*

²⁴⁷Stevens A (2011) *ibid* p96 *Ethnic disparities in drug law enforcement* p96 et seq Where a full account of this is given together with a discussion of confounding factors

stop-and-search routine has now been revised, but whether that will have any effect on the numbers of people detained for drug possession is too early to assess.²⁴⁸

Newcombe²⁴⁹ (2007) commenting on the excessive stops-and-searches, poor arrest rates and ethnic discrimination put it thus:

'...government policies like those identified make a mockery of our criminal justice system...moreover the resources required to carry out annually around half a million drug-resulted stops-and-searches and process over a quarter of a million drug offences are a dreadful waste of taxpayer's money... and a gross infringement of democratic rights'

The government then initiated a review of the matter,²⁵⁰ and that for police officers on street duty:

*There will be a presumption in favour of a verbal warning for adults found in possession of a quantity of cannabis deemed to be for personal use. However individuals must be arrested if the amount of cannabis, its packaging or other circumstances suggest the possibility of an intention to supply*²⁵¹

Legislation is directed towards different types of drug-related offenders: firstly those who have drugs in their possession for their own use. Next those who are involved in the manufacture, growing or trafficking drugs. Then there are crimes, such as burglary, to raise the money to fund the addiction. Finally there are 'secondary' crimes such as occur between rival drug gangs.

If the Law is transgressed, punishment with the removal of freedom follows. Punishment by the State has been justified philosophically in four ways *retribution, deterrence, protection of society and reform of the person punished*²⁵². Fortunately, for the law that is, most drug users who come before the courts, have as their primary offence stealing (to raise the funds to buy drugs) or for trafficking²⁵³, and are sentenced on account of those matters. If it was solely the offence of having possession of drugs for one's own use, then none of the moral justifications of punishment as listed above appear to apply, except for reform of the person to be punished, in other words rehabilitation.

3.4.2 Retribution

Retribution is based upon the principle of retaliation, and social revenge (the called *lex talionis*), the idea of an eye for an eye, and making the punishment fit the crime. Thus a murderer having taken a person's life 'deserves to die'.

Retribution has the concept of vengeance. As Bonneau put it

*If a wrongdoer chooses to violate society's rules, then retribution is deserved and if the wrongdoer harms other people retribution is also deserved.*²⁵⁴

²⁴⁸ BBC News Item 30 Apr 2014 *Theresa May announces reform of police stop-and-search*

²⁴⁹ Newcombe R (2007) *Drug-War Milestone: UK drug searches and drug offences both reach record levels*
Lifeline Project <http://www.lifeline.org.uk/article/drug-war-milestone-uk-dr>

²⁵⁰ May Theresa (2014) *Stop and search: Comprehensive package of reform of stop and search*. Speech in House of Commons on 30 April 2014
<https://www.gov.uk/.../stop-and-search-comprehensive-package-of-reform>

²⁵¹ Thames Valley Police (2015) *Policing Cannabis Possession*
www.thamesvalley.police.uk/pub-policiesandprocedures-policing-cannabis

²⁵² Home Office (1990) *Crime, Justice and Protecting the Public* White Paper Government's proposal for legislation Cm965

²⁵³ Jacobs (2013) *ibid*

²⁵⁴ Bonneau A B (2013) *Offensive drug offences* Boston University Paper
bu.edu/bulareview/files/2013/10/BONNEAU

So that retribution, whatever form that may take is aimed at the offender recognising that they have done wrong and deserves to be punished.²⁵⁵ It has also to be appropriate to the seriousness of the crime; yet vengeance is an emotional concept, and the judiciary has to weigh that in assessing the appropriateness of the sentence. The opinion of the public must be recognised for it would expect the appropriate punishment to be awarded.

In the case of a person arrested for drug possession or usage, they would not *necessarily* be doing harm to themselves or to anyone else, and there would be no moral grounds for the arrest, save of course that the law was being broken. If however, as the result of their addiction their health was failing, they had become ill, and they were harming themselves as a result, then that person is their own victim, and to exert retribution upon oneself, that is to punish on the like-for-like basis, that is to harm yourself more, would be absurd.

Attention should also be given to the causes of the predisposition and addiction to drugs as discussed.²⁵⁶ Retribution would be inappropriate if the person has diminished responsibility, say from mental or personality disorder or if they have genetic impairment which has led to the addiction and crime which followed. The family background and upbringing may well be relevant; in short as described, drug taking and addiction may have a psychosocioeconomic basis which needs to be taken into account if punishment, especially retribution is considered. For a person in possession of drugs for their own use, retribution would seem to have no logical place in punishment, and it would be more appropriate if a warning were issued, as is usually done.

If the offence is production, growing or trafficking, then the person is committing an offence with the potential for causing harm, as shown above²⁵⁷. They are perhaps to be equated with people who sell flick-knives or revolvers; such things are owned to injure other people, unless they are being used for purposes of defence only. Lopez-Quintero and others point out in their survey of 2011²⁵⁸ that most marijuana users *do not* become addicted, but use it for pleasure only. A consequentialist might say that what the trafficker is doing is morally good for the totality of pleasure is increased as a result of the trafficker's activity.

It would be difficult to condone criminal activity such as burglary to get sufficient money to pay for the drugs needed by an addict. But if it is accepted that addiction is a form of compulsion or obsession²⁵⁹, an impairment of personality that is, then it could be argued the addict needs help rather than imprisonment. Indeed it could be said that if they didn't need to steal, but got the drug on prescription as many addicts do, the crime wouldn't have been committed in the first place²⁶⁰ (r) Then the law wouldn't have been concerned with retribution for the loss to the house owner for the goods stolen, but public health would have treated the addict instead. 'Secondary' crimes and their prevention follow the same argument.

²⁵⁵ Langley J (2009) *Crime and punishment*
langley-sec.solihull.sch.uk/Crime%20%Punishmnet

²⁵⁶ Chapter 1

²⁵⁷ Chapter1

²⁵⁸ Chapter 1

²⁵⁹ Tiffany S T & Carter B L (1998) *Is craving the source of compulsive drug use?* J.Psychopharmacol 1998;12(1) 23-30
www.ncbi.nlm.gov/pubmed/9584965

(r) Hari J (2015) in the *Spectator* : *Junk policy. It's the illegality of heroin which leads to the deaths among users.*
Spectator 9 May 2015. In this article he makes a very powerful case for the prescription of heroin to addicts, which is paraphrased at Annex A (q)

²⁶⁰ See Chapter 4 where the Swiss Heroin t) Assisted Therapy trial is reported. Those on therapeutic heroin didn't steal because they didn't need to do so.

3.4.3 Deterrence

Next will be explored the place of deterrence in punishment for drug related offences. The first question to be asked is whether the threat of punishment would be a deterrent for a person contemplating a misdemeanour, say the use of an illegal psychoactive drug, or when that person is undergoing punishment, would that be a deterrence for others? The question which also will be explored is whether the removal of the (threat) of the deterrent would result in unrestricted use of drugs?

Deterrence theory assumes that people are rational beings able to consider and evaluate the possible consequences of their behaviour before committing a crime. However recent studies²⁶¹ showed that 50% of all crimes (including drug related crimes) in the USA are committed under the influence of drugs or alcohol at the time of the offence and in all probability the perpetrator was unlikely to have been fully rational at the time of the offence.

It is accepted that, in accordance with the law, it is necessary to deter individuals from becoming involved in drug use or dealing. Consequently fear of punishment should act as a deterrent by raising the risks in terms of the threat of arrest and incarceration.

However there appears to be evidence that this is *not* the case and as La Follette (2005) pointed out that

*'...these penalties do not deter potential drug crimes. If they did deter, we would expect that drug use ...would have declined. The U.S. Department of Health and Human Services annual report on drug use suggests that the rate of drug use has increased since the passage of the laws (in 2002).'*²⁶²

He goes on to suggest that perhaps the number of drug related crimes might have increased even more without the deterrence of severe penalties, but then goes on to postulate that this is not a plausible supposition, for other crimes, violent crimes and property crimes have decreased by 50-60% during the period under consideration.

Wright reporting in 2010 also from the U.S.²⁶³, reviewing the economic cost of imprisonment, points out those lengthy terms of incarceration show little evidence of deterring future offenses. In the UK report of 1999 from the Police Foundation: *'Drugs and the law'*, it concluded that *'evidence of a deterrent effect was very limited'*²⁶⁴ & ²⁶⁵

A controlled trial of one population subjected to deterrence and the other not, would be a useful way of settling the argument. That is what happened in the Czech Republic, and it was found that during deterrence the drug consumption rate *rose* rather than being suppressed.²⁶⁶ Other countries had similar experiences following relaxation of deterrence and introduction of a degree of decriminalisation as will be shown in Chapter 4.

²⁶¹Wright V (2010) *Deterrence in Criminal Justice ;Evaluating Certainty vs. Severity of Punishment* pp 1 & 5) The Sentencing Project Nov 2010

<http://www.sentencingproject.org/doc/deterrence%briefing%2520.pdf>

²⁶² La Follette H (2005) *Consequences of Punishment*. Journal of Applied Philosophy 2005 pp241
www.hughlafollette.com/.../Collateral%20Consequences%20of%20Punis...

²⁶³ Wright V(2010) *ibid* p 8

²⁶⁴ Independent Inquiry into the Misuse of Drugs Act 1971(1999) *a report for the Police on an Independent Inquiry into the Misuse of Drugs Act 1971 (the 'Runciman Report') under sponsorship of the Joseph Rowntree Foundation 1999*
<http://www.police-foundation.org.uk/uploads/catalogerfiles/inquiry-into-the-misuse-of-drugs...>

²⁶⁵ *As will described in Chapter 4 the experiences in Portugal, the Netherlands and the Czech Republic showed that following decriminalisation of drugs, consumption actually went down.*

²⁶⁶ See Chapter 4 the years of drug re-criminalisation in the Czech Republic (1999-2001) when the Impact Analysis Project, (the 'PAD Report') which assessed those years showed that:

The availability of drugs did *not* decline Adverse health events related to drug taking *increased*
There was a high social and financial cost The number of drug users *increased*
The number of new drug users *increased*

However it would be unwise to discount the value of deterrence altogether, as the findings of the BMA Board of Science put it, for although it may be a credible proposition that deterrence ‘*might help young people to say no*’ it is hard to measure its efficacy with any accuracy.²⁶⁷

3.4.4 Protection of Society

One of the purposes of prohibition, legislation and punishment for the use of psychoactive drugs for recreation is to protect society, as insisted by the Government²⁶⁸; the ensuing argument will explore whether that is effective in punishment for drug related offences.

Punishment implies the limitation of freedom of an individual and it is apposite to recall the views of J S Mill²⁶⁹ on this:

‘...the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others’

Thus harm to oneself does not appear to justify restraint. By implication others joining in with that person’s activity would also not warrant restraint for they are not acting against their own will. So this seems to go against the law as it is. Mill goes on to write that

‘...if a public authority, or a private person, sees anyone preparing to commit a crime...they may interfere to prevent it’ and later when it comes to the sale of poison, (and here we may refer to drug trafficking):

‘... where there is not certainty but only a danger of mischief...that should not be punished..’

This appears to imply that possession is morally acceptable even if supply is suspected but not certain, and is in concurrence with the Government’s recent guidance.

The essence of Protection of Society as a part of punishment is to incarcerate the wrongdoer so that they may do no further harm.

	Possession of Drug	Supply of Drug
Class A	up to 7 years in prison	up to life in prison
Class B	up to 5 years in prison	up to 14 years in prison
Class C	up to 2 years in prison	up to 14 years in prison
	and in each case an unlimited fine	

Table 14 Penalties under the Misuse of Drugs Act 1971²⁷⁰

source Misuse of Drugs Act 1971

Although the sentences in the Act are severe they are modified in accordance with the 2012 Home Office Guidelines.²⁷¹ In effect most offences for personal possession of Class

²⁶⁷ BMA Board of Science ibid p 100

²⁶⁸ Cooper C (2015) *Home Office: ‘Drugs must remain illegal to protect society’* The Independent Newspaper 12 March 2015

Crime: Drugs are dangerous and must remain illegal to “protect society” the Government has insisted, after one of England’s leading police officers called for Class A drugs to be decriminalised.

Mike Barton, chief constable of Durham police, said

“that drugs could be made available to addicts through the NHS, in a controlled supply system that would cut off the income streams of criminal gangs”. His intervention adds weight to growing calls for an overhaul of UK drug policy. “If an addict were able to access drugs via the NHS or some similar organisation, then they would not have to go out and buy illegal drugs,” he added.

²⁶⁹ Mill J S in Warburton(1992) ibid p89et seq

²⁷⁰ Misuse of Drugs Act 1971 see Chapter 1 p 8 for details of the drugs concerned
www.legislation.gov.uk/ukpga/1971/38/pdfs/ukpga_19710038_en.pdf

A, B, or C drugs if repeated more than three to five times result in the offender being required to consent to rehabilitation under a supervision order. If they default they may be given a suspended prison sentence and repeat rehabilitation, with committal to jail as the last resort. Such cases are usually dealt with in the Magistrates' Court with a warning and referral to probation and detoxification.²⁷²

Society is protected by imprisoning offenders, and the total prison population in England and Wales, as at March 2013 was 83,842. Of these 55% had drug related offences,²⁷³ or 'acquisitive crimes' related to generating the funds to buy drugs.²⁷⁴

The cost of imprisonment (2011) is for a man between £34.4-£64.6 thousand a year, and for a woman £50.3-£52.0 thousand.²⁷⁵ The BBC averaged this out to be £41,000 per prisoner per year²⁷⁶ The average earnings for full-time employees in England and Wales was £29 k for a man and £23.7k for a woman²⁷⁷

These facts will be referred to later, when the disadvantages of imprisonment and criminalisation are discussed. The law on drug offences having been noted and the moral situation considered, the actual situation will be described, as outlined in the Report for the Police²⁷⁸ Here it is pointed out that the United Kingdom has the severest drug laws in Europe, *which are in fact usually not imposed*.²⁷⁹ The police recommendation is that there should be no custodial penalty for Class B and C drugs, and that is tacitly accepted by the courts. Furthermore that ecstasy, LSD and buprenorphine (Subutex) should be taken out of Class A and put into Class B²⁸⁰. Their recommendation is that only Class A drug offenders should be considered for imprisonment and in effect the average time in prison was four months, and then they were usually sentenced for other related offences as well as possession.

In effect the vast majority of people stopped and searched and found to be committing a drug offence may be *cautioned conditionally*²⁸¹; that means that the caution is accompanied by a direction to seek help with respect to the drug taking. A caution* does mean that the drug user has gained a police record, and comment on that will be made later.

The Report summarises ;

'Possession offences...constitute around 90% of drug offences...We have concluded that imprisonment is neither a proportionate response to the vast majority of possession offences nor an effective response. A prison sentence should be abolished as a penalty for most possession offences' *'We would expect prison sentences to be imposed only when*

²⁷¹ Home Office 2012 '*Sentencing Council Definitive Guidelines for Drug Offences*'

www.rudifortson4law.co.uk/legaltexts/Sentencing_Council_Definitive_Guidelines_Drug_Offences

²⁷² Jacobs P, Judge (2014) personal communication (see Annex C Acknowledgements)

²⁷³ House of Commons Library (2013) *Prison Population Statistics 2013 Social and General Statistics SN/SG/4334* www.parliament.uk/briefing-papers/sn04334.pdf

²⁷⁴ see Chapter 4 where it is shown that drug decriminalisation in the Netherlands has resulted in eight prisons closing down, for lack of prisoners.

²⁷⁵ Ministry of Justice (2011), *National Offender Management Service 2010-2011* www.justice.gov.uk/downloads/.../2011/noms-annual-report-2010-11.pdf

²⁷⁶ Flanders S (2010) BBC Broadcast 23 April 2010 *average annual earnings* http://www.bbc.co.uk/blogs/thereporters/.../2010/04/slowly_does_it.html

²⁷⁷ Office of National Statistics 2013 *Annual Survey of Hours and Earnings*, www.ons.gov.uk > Home > Publications

²⁷⁸ Independent Inquiry for the Police *ibid* p 5

²⁷⁹ Independent Inquiry for the Police *ibid* p4 para 17

²⁸⁰ Independent Inquiry for the Police *ibid* p 5 para 22

²⁸¹ Wikipedia, *Police caution*

wikipedia.org/wiki/Police_caution

*community and treatment sentence have failed or been rejected*²⁸² If the user is carrying cannabis or khat for their own use they might receive a 'warning' and an on-the-spot fine £90 for cannabis and £60 for khat.²⁸³ but that does not imply a 'record' has been gained by the user.

So far possession has been discussed, where it might be said that society is at little risk and the vast majority of such offences do not result in a prison sentence. In June 2012 there were 12,314 people in prison with drug related offences, 15% of the total prison population²⁸⁴ Of this 3% (1247 persons) were in prison for drug possession.(The others sentenced for possession received suspended sentence 2%, community service 19%, a fine 52% and others 24%)²⁸⁵

Other drug related offences resulting in imprisonment are import/export of drugs (93% are imprisoned), trafficking (46%) and others (13%). If these people are considered to be a threat to society, it seems morally acceptable that they are removed to place where they no longer can pose that danger.

Of the rest of the prisoners, 55% had committed offences connected with the need for money to buy drugs. Prisoners who had used heroin on a daily basis usually spend on average £40 a day on it.^{286 287 (r)}

3.4.5 Reform of offenders

Drug offenders will be considered under the following headings:

- (a) those who are in prison with sentences as outlined above.
- (b) those whom have been given a conditional caution.
- (c) those who have received a warning with or without a fine.

3.4.5.1 Offenders in Prison

75,000 people with drug problems enter prison each year and all drug-dependent prisoners are given full programmes of drug rehabilitation whilst in prison. The aim of rehabilitation is to reduce drug related crime and reoffending after release from prison, and to give drug dependants the opportunity and resources to reintegrate successfully with society.

To coordinate the service the National Treatment Agency for Substance Abuse (NTA)²⁸⁸ was established by government in 2001; it is a separate health authority within

* A police caution is a formal warning given by the police to an adult offender aged 18 years or over and who has admitted that they are guilty of an offence. (a modified caution is used for minors). The aims of the formal police caution are:

- (1)to offer a proportionate response to low level offending where the offender has admitted the offence;
- (2)to deliver swift, simple and effective justice that carries a deterrent effect;
- (3)to record an individual's criminal conduct for possible reference in future criminal proceedings or in criminal record or other similar checks;
- (4)to reduce the likelihood of re-offending

²⁸² Independent Inquiry for the Police *ibid* p 5 para 24

²⁸³ UK Government *Drugs penalties*
www.gov.uk/penalties-drug-possession

²⁸⁴ UK Drug Policy Commission Report 2012 *A Fresh Approach to Drugs* p 62

²⁸⁵*ibid* p 60

²⁸⁶ Prison Reform Trust 2013 *Prison the facts* .page 7
www.prisonreformtrust.org.uk

²⁸⁷ (r) Hari J (2015) *Junk policy: it's the illegality of heroin which leads to the deaths among users.*

Spectator 9 May 2015 p 10-12. Hari assesses the cost of a day's heroin on the street to be £100. He quotes extensively from *Chasing the Scream: The first and last days of the War on Drugs*, Published by Bloomsbury.

the National Health Service and is directed to improve the health services for drug misuse offenders in England and Wales. It functions both in the community and in prisons as the Integrated Drug Treatment System (IDTS) working with the National Offender Management Service and with the Ministry of Justice.²⁸⁹ In prisons it provides counselling, assessment, advice, referral and throughcare service (CARATS). Referral is to psychosocial support teams and clinical management based upon opioid stabilisation and individual cognitive and group behaviour therapy (in accordance with the guidelines recommended by the National Institute for Clinical Excellence).²⁹⁰ 'Throughcare' service implies the planned continuity of care when the offender is released from prison and continues the care programme under the direction of their local GP and in the local detoxification centre.

A report by Price Waterhouse Coopers in 2007²⁹¹ noted the major improvements since drug care in prisons was initiated in 1997. A further report in 2010²⁹² recommended closer interdepartmental integration, improving continuity of care between prison and the outside community and clearer commissioning of services based upon evidence based outcome targets. The concept of a 'Recovery Champion'²⁹³ in the community appointed to monitor the effectiveness of rehabilitation programmes was proposed.

Comment at the Parliamentary Home Affairs Committee in 2012²⁹⁴ was that good progress was being made with treatment of drug addicts in prison; funding had increased fifteen-fold over the years 1997 to 2010; random drug testing had show a 68% fall in positive tests over the same time span and reoffending of drug misusers had fallen 13% in the years 2001-2006.

The National Offenders Management Service reported that for the year 2012-13 in prison treatment course starters numbered 3675, and satisfactorily completed were 3058²⁹⁵. So it could be said that drug related offenders do benefit from treatment in prison; this must be vastly more expensive than treating them in the community.²⁹⁶

3.4.5.2 Offenders in the Community

Both the crown and the magistrate's courts may sentence a drug offender to receive a Drug Rehabilitation Requirement (DRR)²⁹⁷ to undergo treatment for addiction²⁹⁸. The

²⁸⁸ National Treatment Agency (NTS) for Substance Misuse 2001 *Breaking the Link*
www.nta.nhs.uk/uploads/nta_criminaljustice_0809.pdf

²⁸⁹ NTS *ibid* p12

²⁹⁰ NTS *ibid* p13

²⁹¹ Price Waterhouse Coopers (2007) *The role of drug treatment in tackling crime*. National Treatment Agency. www.nta.nhs.uk/uploads/nta_criminaljustice_0809.pdf

²⁹² The Patel Report (2010) *Reducing drug-related crime and rehabilitating offenders*
<https://www.gov.uk/.../the-patel-report-reducing-drug-related-crime-and-rehabilitating-offenders>

²⁹³ Patel *ibid* p.15 *Recommendation 5*

²⁹⁴ Parliamentary Home Affairs Committee (2012) at item 190 *Drug Addiction Treatment in Prison*.
www.publications.parliament.uk/pa/cm/201213/.../184/18409

²⁹⁵ National Offender Management Service (NOMS) 2013 *Annual Report 2012/13: Management Information* for the Ministry of Justice page 34
<https://www.gov.uk/government/uploads/.../mi-addendum.pdf>

²⁹⁶ see Chapter 4 where it is mentioned that the Dutch experience of *not* imprisoning drug offenders *has resulted in the closure of 8 prisons*

²⁹⁷ Report of the Comptroller and Auditor General HC 366 Session 2003-4 *Drug Treatment and Early Lessons* www.nao.org.uk/wp-content/uploads/2004/03/0304366.pdf

²⁹⁸ Drug rehabilitation requirement (DRR's) 2013 *Advice to Offenders*
www.hiwecanhelp.com/your-rights/criminal-justice/DRR.aspx

sentence usually lasts from six months to three years. In 2012-13 satisfactorily completed DRR Orders were 7,000, 58% of the total.²⁹⁹ The offender is under supervision from a probation officer and has to follow their guidance and attend a detoxification centre as well. Usually monthly attendances at court are required when the offender has to submit the probation officer's report for scrutiny by the judge,³⁰⁰ who may if the report is deemed to be unsatisfactory commit the offender to prison.

The treatment routine is based upon stabilisation on methadone or Subutex which is obtained on prescription from the pharmacist. The prescription is free and so the temptation or necessity to steal to raise the funds to pay for the daily fix is removed. The treatment method is based upon the CARAT principles.

3.4.6 Criminal Records

Stops-and-Searches, numbering 1.2 million in 2010-11, were carried out for different suspected misdemeanours: anti-terrorist precautions, knife-carrying or drugs. Table 14 summarises them:

	Searches	Arrests
1986	32,500	6,200 (20)
1990	97,800	16,000 (16)
1995	231,900	30,700 (13)
2000/01	236,900	33,300 (14)
2005/06	377,900	30,400 (8)
2006/07	406,500	33,000 (8)

Table 15 Searches and Arrests for drugs UK 1986-2007

*Lifeline Project. Drug War Milestone, UK Drug searches and drug offences*³⁰¹

How the police carry this out is detailed in the guidelines on the procedure.³⁰² Of the total stops and searches 51% revealed drugs on the person stopped.³⁰³ If a person carrying, for example, some ecstasy tablets in their pockets whilst on the way to a party was stopped and searched by the police and was given a warning, a conditional caution, or arrested and sentenced to a community order or custodial sentence, they would in all cases have gained a 'criminal record', and this could have a profound impact damaging the users future disproportionately to the nature of the crime. Moreover it could paradoxically increase a person's propensity to criminality in the future(t)

The taking of recreational drugs fits uneasily into this pattern. As described in Chapter 1, the number of people, young people especially, using psychoactives to enhance enjoyment is enormous. The vast majority do not progress beyond the 'casual user' category, (90+% in the case of cannabis though there are now moves to relax the law here³⁰⁴ and even if people do become addicted it is by no means certain that they will become incompetent. It

²⁹⁹ National Offender Management Service *ibid* page 22

³⁰⁰ Comptroller and Auditor General *ibid* p 31 .The appearance before the judge was found to be a good motivator to attend to the DRR Order's requirements, for an offender is quoted as saying:

"I was praised by the judge and got a very good probation report. Someone in authority was giving me praise!"

³⁰¹ Newcombe R 2008 Lifeline Project: Drug-War Milestone: *UK drug searches and drug offences both reach record levels*

www.lifeline.org.uk/.../drug-war-milestone-uk-drug-searches-and-drug

³⁰² Metropolitan Police: *Practical Advice on Stop and Search* Produced on behalf of the Association of Chief Police Officers by the National Centre for Policing

[www. content.met.police.uk/.../Satellite?...](http://www.content.met.police.uk/.../Satellite?...)

filename%3D%22436%2F865%2FPractice_Advice_on_Stop_and_Search

³⁰³ Police Powers *ibid*

³⁰⁴ Huffington Post (9 Apr 2014) *Cannabis Legalisation In The UK: Campaigners Welcome Tory Initiative*. www.huffingtonpost.co.uk/.../cannabis-legalisation-uk-tory-bright-blue 5232450.html

is the few that fit into that group, yet all are at risk of being stopped and searched, cautioned or arrested to proceed on the path to gaining a criminal record.

Release (2013)³⁰⁵ points out that in 2010 nearly 80,000 people in England and Wales were found guilty or cautioned for possession of an illegal drug, and mostly they were young, black or poor. Over one million people have been prosecuted over the past ten years for the same reason.

'.. the harms caused by criminalising large sections of society are well established and lead to significantly wasted resources. At a time when the country is facing the deepest spending cuts in modern history wasting enormous resources to police and prosecute individuals for drug possession is unacceptable'

The job and education opportunities which are precluded are extensive as Abrahams (2013) points out³⁰⁶ emphasising the need for 'offenders' of drug related misdemeanours to consider the period of their lives which will be 'lost' whilst their conviction is 'spent':

If the conviction is up to 6 months it will be spent after 7 years

If it is up to 2 ½ years it will be spent after 10 years

If it is over 2 ½ years it will never be spent and people will be debarred for the rest of their lives from many areas of employment.

As mentioned above between the years 2000-2010 a million people had been prosecuted for drug related offences, mainly possession, and all will have gained a criminal record. The stigmatisation, the improbability of achieving responsible and gainful employment; it must have been an enormous economic loss to the country and a huge waste of human potential.

3.5 Does Prohibition Cause Good or Harm?

The motivation for the prohibition of psychoactive drugs of recreation is the belief that they do harm to those who use them, and that the general use of them undermines society. That may well be true but what is also a fact is that many of the harms associated with drugs are not caused by the drugs, *but by the effects of their prohibition*, which as shown above have had devastating effects upon many members of society. (s)

At the same time prohibition is beneficial for some people and this will be mentioned first before the harmful effects are explored.

3.5.1 Prohibition as a benefit to some people

The benefit to potential employers is that people unsuited to a particular employment may be weeded out with the probability of a good decision.³⁰⁷ Such professions as teachers and nurses, who will have to deal with children, solicitors and accountants, who will require honesty in their staff and may be unsuitable if they have a criminal record. In the Armed Forces, Police and Fire Services, a background of violence, ill-discipline and instability would preclude applicants with those tendencies.

³⁰⁵ Release (2013) *Drugs: it's time for better laws* p.1

www.release.org.uk/blog/drug-its-time-better-laws accessed 10092104

³⁰⁶ Abrahams J (2013) *What can't you do with a criminal record?* Prospect Magazine 22 May 2013
www.prospectmagazine.co.uk/.../criminal-record.

details are given of bars to employment in medicine, and related crafts, in the law, the Services, education, voluntary and charitable work; difficulties with benefits, housing, travel restrictions.

(s) see Stuart's Story at Annex A

³⁰⁷ Criminal Background Checks; *A checklist of the pros and cons.*

www.courtcheck.com/pros.pdf

pp 1-4 provides a very comprehensive list, which would be useful to employers and potential employees alike.

The would-be employer could expect the checks to discourage applicants with something to hide, avoid hiring those unsuitable, and thereby reduce possible work, insurance and legal problems in the future .

Prohibition and the passing of the appropriate laws is good for politicians, for it reinforces, in their own perception, and that of their constituencies and the voters upon whom they depend, that they are *'tough on drugs'*, and are doing firm things about it. It would a sure vote loser at election time to be *'soft on drugs'*.

It might be said by some people that by controlling the moral tone of society by legislation they are fulfilling a moral duty, as they see it and as proposed by Forcault.³⁰⁸

The law enforcers, the police, lawyers, judges and court officials all benefit too, for it justifies their existence as it does that of the prison warders³⁰⁹ and all that pertains to prisons. As described above over 50% of prison inmates are there because of drug-related crime; *not* because of the drug, it should be pointed out, but because of the *crime*. And a crime which is a 'victimless-less crime as well, as has been pointed out before.

The greatest beneficiaries are of course the drug producers and traffickers, whose livelihood depends on Prohibition and whose multibillion pound world wide trade would cease if Prohibition were to be abolished. The drugs trade in the UK is said to be worth about £8billion a year.³¹⁰ (u)

As Barnett (2009) put it

'...much of the harm associated with drug use is not caused by the intoxicating action of the drug, but by the fact that such drugs are illegal'.³¹¹

How prohibition harms is what will be explored next.

3.5.2 Prohibition harming individuals

It might be expected to be the case that if something dangerous is prohibited, so that people would be protected from the harm it might cause them, then prohibition should be a benefit for sensible law-abiding people who would have welcomed such a law and obeyed it.

However some people, who want it badly, might try to obtain that illegal and dangerous substance, perhaps of dubious purity, and pay well to those prepared to break the law to supply it, then a black-market of unregulated poor quality and expensive goods develops. And this is of course exactly what happened in the 'Prohibition' in the USA in the 1920's and 30's until its repeal in 1933.

As a result, harm might occur to the individual or to society. A person in the course of acquiring their illegal drugs from their criminal supplier carries the payment in cash and so may be robbed or assaulted, but as they too are engaged in an illegal activity, cannot take the matter to the police. The user may also be subjected to other villainy such as blackmail to avoid their spouse or employer finding out.

Finally as every psychoactive drug user is breaking the law, they run the risk of the police, the courts, and prison and gaining a criminal record with the resultant impairment of education or employment opportunities.

³⁰⁸Forcault M (d 1984) DPMSA lecture 2013 *Forcault : how his theories addressed political power and used it as a form of social control through societal institutions*

³⁰⁹ See Chapter 4 in which comment is made that in 2009 the Netherlands closed eight prisons because of the lack of inmates; 1,200 prison staff were made redundant. Whereas 55% of prisoners in the UK are in with drug-related crimes, in Holland it is 17%.

(u) Further details of the costs of Prohibition are at Annex A

³¹⁰ Morris N 2007 *Britain's illegal drugs trade* is worth up to £8bn a year, a Home Office report has revealed. Independent Newspaper 21 November 2007

³¹¹. Barnett R E 2009 *The Harmful Side Effects of Drug Prohibition* Georgetown Public Law and Legal Theory Research Paper No 12-037 (2009) www.scholarship.law.georgetown.edu/facpub/817

The recreational drug user depends upon criminals to supply the drugs. They are not usually interested in the purity of their goods and so the individual might be poisoned by using impure drugs of unknown concentration as described in Chapter 1 of *What Martha's sad death can teach us*³¹² where the 1/2 gram tablet of ecstasy taken before a party killed the 17 year old, who was found at post-mortem examination to have taken ten times the normal dose. It is to be recalled, as described in Chapter 1 that of the 1,263 people in England who died in 2011 from drug related deaths, 78.4% died 'accidentally' (12.6% were suicides and 8.5% were of undetermined cause).

People who take drugs are indulging in an illegal activity. This makes them less forthcoming when approaching medical practitioners for help; the GP is able to maintain medical confidence, but can reliance be placed upon the reception staff, and other members of the public?

Similarly people, who have become ill as a result of their habit, are reluctant for the same reasons to seek help. Neglected ill health; hepatitis B and C, infected injection sites, thrombosed veins and above all HIV all follow the use of unclean needles, for clean ones have to be obtained from the detoxification centre which as stated above might be under police observation. The 'clean needle scheme' introduced by Norman Fowler, then Health Minister is one of the success stories in the Drug Scene (see Chapter 1) and resulted in a steep fall in the HIV rate in the UK.

The drug habit is expensive, about £40-£100³¹³ (r) per day for heroin, and most users can not afford that, and have to resort to stealing or prostitution to raise the funds.³¹⁴ If the police have a 'blitz' on a certain area to reduce the street dealing rate there, the casual users might use less, but the addicts are unable to reduce their usage so the price goes up because of the scarcity, and the stealing or prostitution has to increase too. If a user is acquiring their drugs legally, that is being an addict by prescription, the street cost is irrelevant, and cost prices to the State are low³¹⁵

Another effect of scarcity is that drugs conventionally smoked may be used intravenously³¹⁶, with the increased risk of infection of the user.

If the scarcity of 'conventional' drugs become more permanent, 'New Psychoactive Substances'(NPS) are either imported or locally made, until government action to identify and classify them has occurred and banning is achieved. In the event substances enter the street market and knowing even less about them, their action and risks, people take them often with serious consequences.³¹⁷ An example is *Phencyclidine hydrochloride (PCP)*, employed industrially³¹⁸, which can be used as a hallucinogen, and cause serious harm to the user.

The main harm of Prohibition to an individual is that caused by the legal processes as described above: reluctance to seek medical help, arrest, court procedures, prison and

³¹² Sandford P (2014) *What Martha's sad death can teach us* Daily Telegraph 15 March 2104

³¹³ Hari J (2015) *Junk Policy* Spectator Magazine 9 May 2015 p10. *Here the writer says the street cost of heroin is £100 a day* a paraphrase of Hari's article is given at Annex A (r)

³¹⁴ Weathers H & Brueggemann C (2014) *Heroin Britain* Daily Mail 15 September 2014
here the reporters write how easy it is to obtain drugs on the street.

³¹⁵ Chief Pharmacist Roy's Wroxham (2014) personal communication 150914 *A maximum maintenance dose of Methadone costs £2.08 for 100mls, for Subutex £19 per day*

³¹⁶ Barnett R E (2009) *ibid* p19 footnote 28 quoting Kaplan J *'In Hong Kong, here although illegal, it was cheap and relatively available, and the drug was inhaled as smoke. In the last few years, however, law enforcement has exerted pressure on the supply of the drug, raising its price considerably and resulting in a significant increase in the use of injection'*

³¹⁷ These consequences of users not knowing the effects of NPS are worsened because if the user is sent to a hospital's A&E Department the staff there do not know what they are dealing with either.

³¹⁸ Barnett R E(2009) *ibid* p20 and footnote 36 quoting Oakley R *'it is very easy and inexpensive to make'*

probation, and the criminal record, causing physical and mental harm to an individual and to their family, and an impairment of employment prospects.

3.5.3 The harm prohibition causes to society

The most obvious harm is the cost of enforcing drug laws. This has been estimated in the UK to be £16 billion a year.³¹⁹ Resources which are used to prosecute a drug user or seller could be otherwise used to investigate and resolve serious crimes.³²⁰ Court time spent on acquisitive crime committed to fund a drug habit, a crime which might well not have happened if drugs were legalised; court time which might better have been spent on dealing with a rapist when there is a victim needing justice.

The cost of imprisonment of drug offenders (mentioned above), an expense for 'law abiding' citizens. These are now the 'victims' of the drug offender's crime, for they are being forced to pay through their taxes for a crime because the morality of prohibition has deemed it to be so.

Not only can the cost of law enforcement be seen to be unnecessary, the application of a legal method of dispensing psychoactive drugs to those who want to buy them, could make a profit for the non-drug using public.³²¹ Some people might consider it immoral to make money out of drug usage; but then taxes are levied on cigarettes and alcohol, which might well go to offset the costs of the illnesses resulting from them.

There is also the human cost of trafficking and drug related gang warfare which results from psychoactive drugs being prohibited.³²² Children aged 12 are used as runners and quoting a research project from King's College Institute for Criminal Policy Research:

'young people's involvement in the drug markets is on the increase....given their backgrounds it is easy to see why some teenagers start selling drugs-as a more exciting and rewarding alternative to slogging away for hours in fast food restaurant or supermarket and a way o earning two or three times more money'

Criminal gangs seeking to expand their markets into the country and out of London, are now using children in their early teens as drug runners on trains especially into South East England.³²³ Trains being used now more than road transport for children being more anonymous than adults, and because the police can track suspect vehicles now with the recently introduced automatic number plate recognition (APNR) technology.

³¹⁹ Politics.co.uk (2009) Home Affairs: *The cost of drug laws: £16 billion* www.politics.co.uk

³²⁰ Hughes and Stevens (2012) pointed out that in Portugal arrests for opportunist (*non drug-related*) thefts appeared to have *increased* in number, perhaps because the police had more time to follow up these offences, having been freed of the need to deal with petty drug offences.

³²¹ Reutermann R (2010) (special advisor to CNBC) *Cost benefit arguments around enforcement*. He stated that: *'...regulation of drug markets also creates opportunities for generating revenue through taxation. A speculative report by Harvard economist Jeffrey Miron estimated that legally regulating drugs in the US would yield roughly \$46.7 billion a year in tax revenue, and would save approximately \$41 billion a year in government expenditure on the enforcement of prohibition.'* www.cnbcm.com/id/36600923

³²² Campbell D (2005) *Revealed: Britain's network of child drug runners* The Guardian Newspaper 15 Oct 2005 *The fullest survey yet into the UK's crack and heroin trade shows it is fuelled by children and teenagers*

³²³ Copping A. (2014) *London gangs using children as drug mules as they seek to expand markets* The Guardian Newspaper 5 Jan 2014 *Children as young as 11 are being used as mules to carry drugs on trains out of London*

International trafficking uses ‘mules’ to carry drugs across borders,³²⁴ and gangs specialise in the importation, production and sale of illicit drugs. Of the 2,800 gangs identified within the United Kingdom it is estimated that 60% are involved in drugs.³²⁵ Mostly they are European British but there are also drug gangs of Asian or Afro-Caribbean ethnicity. Gangs, by their presence degrade a neighbourhood; make it unsafe for people to live in, or for the police to control.

The international drug trade is controlled by ‘cartels’ criminal organisations originally developed with the primary purpose of promoting and controlling drug trafficking operations. They range from loosely managed agreements among various drug traffickers to formalised commercial enterprises. The term was applied when the largest trafficking organizations reached an agreement to coordinate the production and distribution of cocaine.³²⁶ The term is now applied to any international organisation involved in the drug trade.

World Health (1996) estimates the international total revenue accruing to the illicit drug industry ranges between US\$ 300bn and US\$500bn, approximately 8% of the total international trade. This is larger than the international trade in iron and steel and is about the same size as the total world trade in textiles.³²⁷

Apart from the financial aspects of international drug trafficking there is the human cost. Human Rights Watch estimates that from 2006 to 2012 in Mexico alone more than 60,000 people have died in feuding between the cartels, with political destabilisation and impoverishment of the country.³²⁸

3.6 Summary

The advantages and disadvantages of prohibition and the ensuing legislation have been examined and defined. It seems that the evidence is clear that what advantages there may be are significantly outweighed by the disadvantages. Prohibition does not act as deterrent. It is not a benefit to the individual, rather results in personal harm as well as being in general harmful to society. It is the cause of significant expenditure. Trafficking warfare has resulted in a large death toll and political destabilisation of many countries. The world generally appears to be of the same opinion, for in 2014 the World Health Organisation recommended that

‘Countries should affirm and strengthen the principle of providing treatment, education and rehabilitation as an alternative to conviction and punishment for

³²⁴ United Nations Office on Drugs and Crime(2014)*Drug mules: Swallowed by the illicit drug trade* UNODC Report www.unodc.org/.../drug-mules_-swallowed-by-the-illicit-drug-trade.html:

The Report quotes the following story:

"My mother decided to meet with someone - I didn't know who that someone was. It was a man. She had sold me to a trafficker..."

"I was forced to swallow 86 balloons and taken to the airport. At the airport, one of the victims became very ill. She said to me that a balloon containing the drugs had popped .Flight attendants were unhelpful because they thought I was drunk, so I had no choice but to keep shut... She collapsed right there. It all happened so fast; I watched her die, it was painful and especially when you have drugs inside yourself too. I was crying and didn't know whom to turn to for help" DJ's story.

³²⁵ Wikipedia, *Gangs in the United Kingdom*

www.wikipedia.org/wiki/Gangs_in_the_United_Kingdom

³²⁶ Wikipedia, *Drug cartels*

www.wikipedia.org/wiki/Dr_a

³²⁷ World Health Drug Report (1996): *Highlights: recent trends and developments in cultivation, production, trafficking and distribution of drugs of abuse.*

www.un.org/ga/20special/wdr/e_hilite.htm

³²⁸ Human Rights Watch (2013) *Mexico Drug War Fast Facts*

www.cnn.com/2013/09/02/world/americas/mexico-drug-war-fast-facts/

*drug-related offences. Currently many countries make major expenditure on imprisonment of drug dependent people, an approach associated with very high relapse rates soon after release. There is no evidence that such an approach is effective or cost-effective*³²⁹

In 2011, Kofi Annan, the past Secretary General of the United Nations had stated at the UN Global Commission on Drug Policy that

*“the global war on drugs has failed, with devastating consequences for individuals and societies around the world. Fifty years after the initiation of the UN Single Convention on Narcotic Drugs, and 40 years after President Nixon launched the US government’s war on drugs, fundamental reforms in national and global drug control policies are urgently needed”*³³⁰

The UN convention to do this is planned for 2016.

The next chapter will illustrate how five countries, selected because of their successful outcomes, have developed their drug policies.

³²⁹ WHO 2014 *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*, p38. WHO Library Cataloguing-in-Publication ISBN 978.92.4.150743.1(NLM Classification WC 503.6)

³³⁰Report of the Global Commission on Drug Policy
www.globalcommissionondrugs.org/.../Global_Commission_Report_Eng.

Chapter 4. Legalisation or Decriminalisation? An analysis of five countries' drug policies.

This Chapter explores how some countries, as the alternative to prohibition, are attempting risk avoidance and harm reduction through a measure of decriminalisation and legalisation. The countries examined, Portugal, The Netherlands, Switzerland, Germany and the Czech Republic, have been selected because the EMCDDA statistics show there is good evidence to consider that their drug policies are successful. How they have achieved that is explored, by methodological analysis so that lessons might be learned by other countries.*

4.1 Introduction

In Chapter 2, I explored the morality of taking psychoactive drugs with the conclusion that rational people should be free to decide for themselves whether they took drugs or not. As long as they did not cause others harm, or harm to society because of the effect of an addict's debility, inability to contribute to the welfare of society and the uptake of medical resources to care for them.

Chapter 3 examined prohibition of the use of recreational drugs. It identified the significant harms to the individual, society and internationally through the illegal drug trade. It seems obvious that more harm than good is being done through criminalisation. It became clear that the case for prohibition could not be sustained and that alternative methods of coping with the problems of drug use have to be devised. The reason for assessing the impact of prohibition was that internationally the official thrust of activity is still in that direction, despite that it appears to have failed to prevent drug usage.

Many countries,³³¹ & ³³² are in fact now moving away from prohibition and channelling illegal recreational psychoactive drugs into programmes, not only reducing usage but also their risks and harms.

This gradual, covert, approach is because the public ideology for many people and for some newspapers is that all drugs are 'wicked',³³³ & ³³⁴ or scientists stupid³³⁵ and for politicians, professional suicide to be 'soft on drugs'; they have to be tough. Yet things are changing as is reflected in reputable newspapers.³³⁶

In this Chapter the terms *decriminalisation* and *legalisation* are used. The understanding of what is meant by them varies, but for now they will be defined thus:

*EMCDDA: European Monitoring Centre for Drugs and Drug Addiction

³³¹ The Week Magazine 11 July 2014 *The pros and cons of legalising drugs. A tide of support for legalising drugs seems to be rising around the world. Could it work here too?* This article describes how Jamaica is in the process of legalising cannabis, and anticipates a good export market to the USA where the states of Colorado and New York permit cannabis use and other states are likely to follow suit. (London 2014)

³³² The Guardian 25 June 2014. MacAskill E. *Former UK ambassador to Afghanistan calls for legalisation of drugs.* The writer interviews Sir William Patey who admits UN policy in Afghanistan has failed and proposes instead that the opium crop should be bought up by the western powers and made available to users through a legally regulated market. (London)

³³³ Phillips M (2011) *Drug legalisation? We need it like a hole in the head* Daily Mail. 19 Nov 2011

³³⁴ Phillips M (2009) *The Nutty professor, fatuous, dangerous, utterly irresponsible* Daily Mail 4 Nov 2009
This referred to Professor Nutt's assertion that smoking cannabis is less dangerous than riding a horse.

³³⁵ Glover D (2010) *Why doesn't this dangerous man come clean and admit he wants to legalise drugs?* Daily Mail 3 November 2010 Professor Nutt said alcohol is three times more harmful than cocaine

³³⁶ Aaronovitch D (2013) *Legalise Drugs And You'll Save People's Lives.* The Times 6 Oct 2013

Decriminalisation: the abolition, reduction, or alteration of the laws on use of illegal psychoactive drugs.

Legalisation implies that their production, supply, provision and usage would either be free from control, or subject to controls of quality, purity, concentration, quantity of the drugs, of the premises on which they are consumed and of the people supplying them.

Neither term will be defined further at this stage, for first the way how some countries are doing this will be explored, and then a synthesis made of '*best practice*', with perhaps redefinition and refinement of these terms.

Only Portugal, the Netherlands, Germany, Switzerland and the Czech Republic will be analysed, not because other States, such as Australia and the Southern and Middle American States, which show features of great interest, are unworthy of study, but because of the constraints of time and words placed upon this project.

Many Northern European countries are moving towards legalisation and decriminalisation, with the Netherlands starting fifty years ago. The impetus was the 'youth culture' of the time, the 'swinging sixties' of freedom, love and rejection of authority. The Dutch Minister of Health at the time appreciated that young people were going to experiment with drugs whatever their elders thought; she felt they should be allowed to do it in a regulated way on controlled premises (in clubs and 'coffee-shops') so that the risk of harm was minimised.^(v) From that developed the current drug policy in Holland.

Portugal's move followed the realisation that it had the highest HIV infection rate in Europe,³³⁷ resulting from heroin use with contaminated needles. Decriminalisation and legalisation measures followed with impressive outcomes.

In the United States by contrast the 'clean-needle scheme', introduced in the 1980's was withdrawn in 1988, for it gave, seemingly the 'wrong message' to society: connivance in a sinful act. The clean-needle scheme was reinstated in 2009 and withdrawn again in 2011. Nowadays most US states have such schemes circumventing the law.³³⁸ The result however is that the US has now one of the highest HIV rates in the western world.

The UK commenced legalisation in 1986 when the clean-needle scheme was introduced, thus making sort-of-legal the taking of (illegal) drugs under certain circumstances. The outcome is that the UK has now one of the lowest HIV/AIDS rate in Europe.

Switzerland began legalisation in the 60's with the notorious 'needle park' in Zurich. The citizens there wouldn't put up with the resulting disorder and 'drug consumer rooms', and needle exchange sites became the precursor of today's 'Four Pillar Policy' drug policy.

The Czech Republic's move was prompted by a reaction to the prohibition, repression and austerity of the communist era. Total relaxation of the drug scene was followed by re-imposition of penalties, concurrently with a scientific survey of what happened next. The outcome evidence showed that matters *worsened* during the two years of prohibition. That initiated the introduction of a tariff of legal drug possession and the adoption of a drug policy similar to the Swiss Four Pillar strategy.

^(v)typical Dutch pragmatism; another example in the author's experience is described at Annex A

³³⁷ Wikipedia, *Drug policy of Portugal*. In 1999 Portugal had the highest rate of HIV amongst injecting drug users in the European Union wikipedia.org/wiki/drug_policy_Portugal

³³⁸ Wikipedia, *Needle exchange programmes* wikipedia.org/wiki/needle_exchange_programmes

4.2 Portugal

In 2001 Portugal started decriminalisation and legalisation and this has been extensively reviewed by Stevens,³³⁹ in part to advise the House of Commons Home Affairs Select Committee.^{340(w)}

The main features were that a user's possession of a ten days' supply of psychoactive drugs, is allowed, though technically still illegal,^{341 (x)} and is found by the police, no further action is taken. If a person has an amount exceeding these values, it is considered possession-for-sale, which is subject to the *civil not criminal law*; punishment is through fines, community service and referral to 'Commissions for the Dissuasion of Drug Addiction' (*Comissões para a Dissuasão da Toxicodependência*-CDT).³⁴² These commissions are made up of a social worker, psychiatrist, and solicitor, who focus on the individual's treatment needs, encouraging dependent users to seek help, investigate and advise on their social and economic situation, may initiate the offender's reporting back to monitor progress and if necessary have the authority to issue sanctions. About 76% involve cannabis, 11% heroin, 5% cocaine and the rest mixtures of drugs.³⁴³

An offender who is a casual user may be banned by the CDT from visiting clubs, discos and associating with other users. They can be fined, or ordered to carry out community work. An unemployed person might have their benefits withheld until they attend rehabilitation. If they are in a profession or job where their competence could be impaired, they might be suspended from it. A person refusing to attend rehabilitation may be fined, or as a last sanction, imprisoned.

The work of the CDT is directed towards reintegrating the drug offender into society, rehousing where indicated, and encouraging the work ethic. The method of rehabilitation follows lines similar to those in the UK and methadone is used as the standard replacement. All pharmacists offer free clean needle kits upon request.

The outcome of the Portuguese experience is that crime has decreased since decriminalisation. Drug related offences 14,000 in 2000 fell to 5,500 by 2012, and the prison population of drug offenders declined from 44% of inmates in 1999 to 21% in 2012.³⁴⁴ This resulted in a significant reduction of prison overcrowding. Of interest, as Hughes and Stevens (2012)³⁴⁵ pointed out, is that arrests for *non drug-related* thefts appeared to have *increased* in number, perhaps because the police now had more time to follow up these offences, freed of the need to deal with petty drug offences. They commented that the theory would be difficult to prove, but that it was probably supported by the fact that *drug-related* acquisitive offences also decreased during the same period.

(w) for the opinion of the UK Home Secretary on the Portuguese drug policy see Annex A

(x) see Annex A for the full list

³³⁹ Stevens A (2012) *Portuguese Drug Policy shows that decriminalisation can work but only alongside improvements in health and social policies* LSE Comment 2012 acc 23092014
blogs.lse.ac.uk/euroblog/2012/.../Portuguese-drug-policy-alex-stevens..

³⁴⁰ House of Commons Home Affairs Select Committee on Drugs (2012) *Drugs: Breaking the Cycle*
www.publications.parliament.uk > ... > Home Affairs

³⁴¹ Wikipedia, *Drug policy of Portugal* en.wikipedia.org/wiki/Drug_policy_of_Portugal acc 26092014

³⁴² Murkin G (2014) *Drug decriminalisation in Portugal, setting the record straight*. Transform1110614
www.tdpf.org.uk/.../drug-decriminalisation-portugal-setting-record-straight.

³⁴³ Release (2011) *A Quiet Revolution: Drug Decriminalisation Policies in Practice Across the Globe*
www.release.org.uk/.../quiet-revolution-drug-decriminalisation

³⁴⁴ Murkin (2014) *ibid*

³⁴⁵ Hughes C E & Stevens A 2012 *A resounding success or a disastrous failure: Re-examining the interpretation of evidence on the Portuguese decriminalisation of illicit drug usage*.
<https://ndarc.med.unsw.edu.au/.../resounding-success-or-disastrous-failure>

Deaths from illicit drugs also reduced significantly from 80 in 2001 to 16 in 2012,³⁴⁶ though it is not made clear whether these deaths were due to accidental poisoning or suicide. It should be pointed out that the former would not be likely since drug legalisation as such does not exist in Portugal, so the quality, purity and concentration of illegal drugs is not under any (official) control, though individual examples of testing now occur.³⁴⁷ It might be inferred therefore that this successful reduction in death rate would seem to be attributable to the improved care and services given to addicts.

Usage of illicit drugs is now within the European average, and has declined in the 15 to 24 year age group, those most at risk in the initiation to drugs.³⁴⁸ This too is of interest, for as drugs are not legally available, the 'pushers' must still be around, yet seemingly not so effective. Overall drug usage has decreased; the numbers of people injecting and the number of 'Problematic Drug Users' (q) fell from 100,000 in the early 1990s to 50,000 in 2012.³⁴⁹ & ³⁵⁰ Injecting HIV+ drug users have decreased from 1,016 in 2001 to 56 in 2012; cases of AIDS from 568 to 38. Cases of Hepatitis B and C have also decreased in number, and the number of people attending treatment centres has increased.

Although legalisation, as such, of psychoactive drugs is only permitted in Portugal in that possession, within limits, is allowed, moves are being made by left wing parties (the *Bloco Esquerda*) to permit cannabis growing for personal consumption and perhaps for use in 'cannabis clubs'. These proposals include permission for a person to own up to ten plants and to store sufficient for one month's use. Cannabis clubs would be non-profit making associations avoiding the risk that they might push the sale and consumption of cannabis, for that is thought to be the case in the Netherlands' coffee shops which are commercial establishments.* The cannabis clubs proposed would be strictly regulated and controlled, as would growing overseen by the National Pharmaceutical and Drugs and Health Products Authority and the local government authority.³⁵¹

Portugal has made significant progress in reducing the harm caused by illicit drug use. It has also reduced the potential criminalisation of a large number of young people. However, as Murkin³⁵² points out much of that gain may now be under threat because the economic downturn.

³⁴⁶ Murkin (2014) *ibid* p2

³⁴⁷ Channel 4 News 30 September 2013 Lynch C (2013) *Nightclub drug tests: saving lives or quality control*. Describes how many nightclubs in Portugal, Spain, Switzerland and the Netherlands have installed near the entrance to the club a room for experts to assess drug purity for partygoers to have their drugs voluntarily checked. The article quotes Professor Nutt's approval of this.

³⁴⁸ Release (2011) *ibid* p 31.

**the significance of this is that although it is legal to possess psychoactive drugs, it is illegal to acquire them. So they still have to be bought 'on the street', with all the potential risks that this implies and which have been outlined in detail in Chapter 3. This is called in the Netherlands the 'back door/front door problem'. Cannabis may be legally consumed and sold in the cannabis 'coffee shops' (the 'front door'), but only illegally bought, (through the 'back door').*

³⁴⁹ Release (2011) *ibid*

³⁵⁰ Man, Louise (2007) *Estimates of the Prevalence of Problematic Drug Use in needs assessment guidance for adult drug treatment...* Home Office July 2007
www.nta.nhs.uk/uploads/guidance_using_pdu_estimates.pdf
 At Annex A(q) a synopsis of the Report is given. It illustrates the overall characteristics of Problematic Drug Users in the UK

³⁵¹ *I have been told that this has not now happened (personal communication Ricardo from his sister Ana, (see Annex C Acknowledgements), for the election resulted in a right wing government of 'conservative' inclination towards drugs policy and are discouraging further progress in drug policy.*

³⁵² Murkin G (2014) *ibid* p3

This has subsequently forced the government to reduce funding for health and drug care facilities which can no longer afford the services they used to provide with such success.

To summarise Portugal's drug policy: possession for personal use and growing one's own is now established. There had been *no overall increase* in drug usage. The drug care programme is handled by the civil authorities and not the police, with the object of maintaining drug users integration into society, with encouragement and if necessary coercion into treatment, and the avoidance of gaining the stigma of a criminal record. There are 'clean needle' and methadone replacement schemes and the provision of drug testing before public musical events.

The outcome has been a very steep fall in drug-related deaths, PDUs and IDUs, HIV and hepatitis. In addition the prison population of people with drug-related offences has halved and there has been a 2/3 reduction in drug-related crimes.

4.3 The Netherlands*

As already mentioned in Chapter 1 the International Opium Convention held of 1912 and registered in a League of Nations Treaty in 1922. The Convention banned all drugs of addiction.

In the Netherlands opiates, cocaine and cannabis were prohibited in law in 1928,³⁵³ and the latter was only made illegal in 1953. However the laws were never seriously enforced owing to the Dutch concept of '*gedogen*'³⁵⁴ which implies that even if an activity is illegal it need not be treated as such unless it causes harm to others.³⁵⁵ A general tolerance of the use of psychoactive drugs developed until the 1960's when two events occurred which caused the Dutch to regularise matters.

A wide-spread feeling of unrest against the political establishments had developed amongst the youth of Europe. In Holland this was directed against the authoritarianism of the two main parties in Government, the one being Catholic and the other Calvinist, both being influenced by a somewhat conservative ideology, and the feeling that society had become more lax than it should have been. The youth movement on the other hand believed that more freedom, as it saw it, was needed; more drugs, women's' rights, sexual liberalisation, protection of the environment and fewer laws and rules.³⁵⁶

The other matter which concerned the government was the sudden rise in heroin use, due to the successful interception of imports of opium (which was taken by the safer route of smoking), and which coincided with the arrival on leave of large numbers heroin-dependent American servicemen stationed in Germany.³⁵⁷

In the mid 1970's the then Minister of Health and the Interior, Irene Vorik, commissioned reports on the different drugs circulating in Holland. She concluded that young people experimented with drugs as a natural part of the process of maturation, but faced less potential harm from a 'soft' drug such as cannabis,(y) and more from the 'hard' drugs such as heroin and cocaine. They were being introduced to drugs through street suppliers, and if, she felt, the supply of soft and hard drugs could be separated, through soft drugs being smoked in the existing youth clubs, from hard drugs on the street, that should

* I shall use the words Netherlands, Holland, Dutch and Netherlands interchangeably

³⁵³ Wikipedia *The International Opium Convention*
http://en.wikipedia.org/wiki/International_Opiium_Convention accessed 021014

³⁵⁴ I am grateful to my wife's cousin Dr Sophie Elpers-von-Samson-Himmelstjerna of The Royal Netherlands Academy of Sciences who confirmed the meaning of these words (021014)

³⁵⁵ Stevens, (2011) *A Drugs, Crime and Public Health* Routledge. page 120

³⁵⁶ Wikipedia *History of the Netherlands*
en.wikipedia.org/wiki/History_of_the_Netherlands

³⁵⁷ Stevens, (2011) *ibid* page 120

act in protecting young people from serious harm, for they might be inclined to take the easier, cheaper and safer option of soft drugs out of sight of the police. From this arose the ‘coffee shops’* which exist today. She also advised the police not to prosecute the use and sale of cannabis on these premises, yet keep up the pressure on the street dealers of hard drugs.³⁵⁸

4.3.1 The ‘Gedoogbeleid’ concept

Cannabis is still technically illegal as are the coffee shops, but the Ministry of Justice issues guidelines applying ‘*gedoogbeleid*’ the ‘tolerance policy’ which lays down the non-prosecution criteria. Thus essentially decriminalising cannabis.³⁵⁹

Further commissions were established: the Hulsman Commission, formed from the National Federation of Mental Health Organizations, which stated that

Use and possession of small quantities of cannabis should be decriminalised immediately, but not other drugs. It was felt that if all drug users were ‘marginalised’ together the soft drug users may be inclined to move into hard drugs. However they found no evidence at the present of the ‘stepping stone’ theory (gateway theory).³⁶⁰

The Baan Commission consisted of members of the Judiciary and Police, psychiatrists and sociologists. They stated that

Drugs should be grouped into those with ‘unacceptable’ risks and those with ‘acceptable’ risks; i.e. Group 1 hard drugs and Group 2 soft drugs.

Drugs should be handled legally under a civil not criminal code, with the aim of coercing heavy users into treatment. Drug users are better served by drug information and prevention than by prosecution.

Much drug usage is short-lasting experimentation by young people. If the so-called deviant behaviour of youngsters is stigmatised by punitive measures, there is a serious danger of the probability of intensification of it. This may initiate a downward spiral, making the return of the individual to a socially acceptable lifestyle increasingly difficult. Cannabis use should take place only in recreational circumstances and not when driving or operating factory machinery.³⁶¹

Following the two commissions the Dutch ‘Opium Law’ (*Opiumwet*), which covers all psychoactives, was amended in 1976, and has remained largely unchanged since. It states that drugs of recreation classified as Group 1, unacceptable risk and Group 2 an acceptable risk of addiction and harm. Cannabis dealing in the coffee shops would be permitted as long as the dealers refrained from selling hard drugs, and ‘coffee shops’ began selling cannabis, with the law being amended in 1996 to issue new regulations for them viz: ³⁶²

* in Holland a ‘coffee shop’ is where you may smoke cannabis; a ‘cafe’ is for coffee and cakes

³⁵⁸ Dronkers B (2014) *A History of Cannabis in Holland*

www.kindgreenbuds.com/marijuana.../a-history-of-cannabis-in-holland/

³⁵⁹ Thompson N (2013) *Cannabis Culture and entrepreneurship* WordPress. com the cultural entrepreneur .wordpress.com/tag/cannabis/

³⁶⁰ National Drug Policy, The Netherlands (1971) *The Hulsman Commission*
<http://www.parl.gc.ca/content/sen/committee/371/ille/library/dolin1-e.htm>

³⁶¹ National Drug Policy, The Netherlands (1971) *The Baan Commission* www ibid

³⁶² Ministry of Health, Welfare and Sport (1997) *Drug Policy in The Netherlands* www.ukcia.org/research/dutch.php

No more than five grams of cannabis per person may be sold in any one transaction or per day; fortified brands of cannabis were banned by later amendments to the law
 No hard drugs may be sold;
 Drugs and the shop may not be advertised;
 The coffee shop must not cause any nuisance;
 Drugs may not be sold to under 18's, nor may they be admitted to the premises
 More than 500 grams may not be held in stock at any one time
 The mayor may order a coffee shop to be closed if it is felt that these rules are being broken.

Ministry of Health, Welfare and Sport

Table 16 -Coffee Shop Regulations-

Local regulations prohibited the siting of coffee shops within 250 metres of a school. By 2012 the nuisance of foreigners being attracted to them resulted in local laws requiring some to be turned into clubs with limited membership, thus excluding visitors, or asking for their identity, or admission only in the evenings.³⁶³ These rules are strictly enforced and if infringed the coffee shop is closed down with little or no right of appeal.³⁶⁴

Cannabis users may take their drug to the local town hall for purity testing, though this facility may now have been suspended. In 1993 the Dutch government issued guidelines to local councils for 'house parties' (raves), for them to decide whether to ban or allow them. Many councils now stipulate that the organiser of raves have to provide drug quality testing at the entrance (provided by the Drugs Advice Bureau's *Safe House* Project), with first aiders on duty.³⁶⁵

Drug consumption rooms (DCR) (*gebruikersruimten*) were initiated in 1990, the first one being in a church and by 2003 there were twenty two.³⁶⁶ Their objects are to reach high risk drug users, men usually and often homeless ex-prisoners. Some DCRs are for women street sex workers. They provide a safe hygienic environment for injecting users under the supervision of trained staff. They promote the health of users, reducing morbidity and mortality, and public nuisance on the streets.

³⁶³ Mallat F R (2012) *Fumones del mundo, no teman (smokers of the world, don't worry)*
 Cannabis info. La enciclopedia en línea sobre el cannabis
www.cannabis.info/CA/enciclopedia/3715-fumones-del-mundo-no-teman

³⁶⁴ The Daily Smoker 7th October 2014 *What are the rules for coffeeshops in Amsterdam?*
www.dailysmoker.com › 420 Info › Various › Amsterdam › Drug Policy

³⁶⁵ Daruvalla A (2014) *Dutch ravers can mellow out as official tests make Ecstasy safe* The Independent Newspaper
 29 December 2014 The article (from Amsterdam) refers to the fact that a teenager at a rave in Blackpool died after taking Ecstasy, which has been avoided in Holland since the 1990's

³⁶⁶ EMCDDA Heidrich D et al (2004) *European report on drug consumption rooms*
 · www.emcdda.europa.eu/.../att_2944_EN_consumption_rooms_report.pdf

Deprivation is associated with a higher rate of drug taking as shown in Tale 17

	NL	UK	Europe(28 countries)
Gross domestic product	128(2012)	106(2012)	100
Unemployed/100,000	6.7(2013)	7.5(2013)	10.8(2013)
in under 21 year olds	11.0(2013)	20.5(2013)	23.4(2013)
Poverty rate	10.1(2012)	16.2(2012)	17.0(2012)
Prison Population/100,000	67.7(2012)	152.1(2012)	

Table 17 *Source EMCDDA Statistics* Deprivation Indicators

These figures show that the income of individuals is about 20% more in Holland than it is in the UK; there is more poverty here too and the unemployment rate for younger people in England and Wales is twice that in the Netherlands. The prison population in the UK is almost three times higher and is the highest in Europe. As has already been mentioned above, in the UK prisoners with drug related offences form 55% of the prison population; reported drug related offences in Holland are 1/4 that of the UK.³⁶⁷ Table 18 gives details.

	UK	NL
Hard drug addicts/100,000 ³⁶⁸	2.6 (1995)	1.6 (1995)
Arrests for cannabis/100,000 ³⁶⁹	206(2005)	19 (2005)
Percentage in prison for drug related offences	55%(2000)	17%(2000)*

Table 18 Drug addiction and offences in UK and Netherlands

A comparison of the two countries and with the UK and Europe as a whole shows how widely different the drug taking habits are: In prison for drug related offences in the UK are 264/100,000³⁷⁰ and in Holland there are 127/100,000³⁷¹. As Stevens³⁷² pointed out the relationship between drugs and crime is far from straightforward, but it would not be unreasonable to expect that some of the difference might be due to the different approach to drugs in the two countries.

*It is of interest to note that in 2009 the Netherlands closed down eight prisons because of the lack of inmates. 1,200 prison staff were made redundant and spare prison capacity was loaned to Belgium³⁶⁷ and Norway³⁶⁷

³⁶⁷ EMCDDA Possession of cannabis for personal use - - Europa .emcdda.europa.eu › Countries › overviews

³⁶⁸ EMCDDA Country overviews - - Europa emcdda.europa.eu › Countries › overviews

³⁶⁹ EMCDDA Possession of cannabis *ibid*

³⁷⁰ Huffington Post (2014) *Netherlands Closes Eight Prisons Due To Lack of Criminals*

³⁷¹ Daily Telegraph(2014) *Netherlands to rent jail cells to Norway*

³⁷² Stevens (2011) *ibid* p 36 *et seq* and p 122

	UK	NL	Europe (28countries)
Problem Opiate use (rate/1000)	8.1(2010-11)	0.9(2012)	0.2-10.7
New Opiate treatments started %	33.4 (2011)	5.7(2012)	2-86
Injecting Users /1,000	3.3(2004-11)	0.2 (2008)	0.2-5.9
Deaths from drugs /1,000,000)	38.3 (2012)	10.2 (2012)	2.0-190.8
Cannabis			
% school children	25 (2011)	27 (2011)	5-42
% young adults	10.5(2012-13)	13.7(2009)	0-19
% all adults	6.4 (2012-13)	7.0 (2009)	0-10
Cocaine			
% school children	5.0 (2011)	2.0(2011)	2-86
% young adults	3.3 (2011)	2.4(2009)	0-4
%all adults	2.0 (2012-13)	1.2(2009)	0-2
Amphetamine			
%school children	4.0 (2011)	1.0(2011)	1-7
% young adults	1.1 (2012-13)	NK	0-3
%all adults	2.8 (2011)	0.4(2009)	0-67

Table 19 Drug usage comparisons between UK and the Netherlands

Source: European Monitoring Centre for Drugs and Drug Abuse Annual Reports ³⁷³ & ³⁷⁴

It is noted that the cannabis³⁷⁵ usage is higher in Holland than in the UK, even amongst schoolchildren; but this is the widely used soft drug obtainable in the coffee shops. It could be assumed that the adults procuring some there illegally give it to children, which is regrettable but not life-threatening(y). On the other hand the hard drugs taken are significantly less in all categories, and especially so with opiates. In UK the problem user rate is almost ten times that in the Netherlands, injecting rates the same and deaths from all drugs four times higher in the UK. Moreover the needle exchange rate is now falling in Holland, confirming the fall in numbers of injectors (Stevens).³⁷⁶

In 2008 the Dutch Parliament debated the 1995 Drug Policy and called for a report to evaluate the situation,³⁷⁷ for a new policy paper. This reiterated the aims of the original policy being firstly to effect harm reduction, through separating recreational drugs with an acceptable health risk from those with an unacceptable risk. The second aim being to avoid stigmatisation and criminalisation so that drug users and offenders may be swiftly reintegrated into society. Both these aims had been largely achieved.

³⁷³&³⁷⁴European Monitoring Centre for Drugs and Drug Abuse *Statistics*
<http://www.emcdda.europa.eu/counties/data-sheets/united-kingdom>

³⁷⁵ Stevens(2011) *ibid p...* Cannabis is not without its risks and a discussion of that is given at Annex A (y). The point of significance is that it is much less harmful and less addictive than all other psychoactive drugs, even less so than nicotine or alcohol, which is why the Dutch allowed it in the first place.

³⁷⁶ Stevens(2012) *Examples of depenalization* p 120 et seq.

³⁷⁷ van Laar M & van Ooyen-Houben for the Ministerie van Veiligheid en Justitie(2009) *Evaluation of the Dutch national drug policy* <https://english.wodc.nl/.../evaluatie-drugsbeleid.aspx?cp=45&cs=6796>□

In the Report the authors examined the five epidemiological indicators set by the European Monitoring Centre for Drugs and Drug Abuse which were the

1. *Prevalence of drug users in the general population and in schools*
2. *Prevalence of Problematic Drug Users*
3. *Demand for treatment on account of drug use*
4. *Infectious disease rate related to drug use*
5. *Drug related death rates*

At the end of the assessment of indicators the authors conclude that

*'we may conclude that the Netherlands scores 'average to well' on the indicators of the EMCDDA. However with ecstasy use in general and cannabis use amongst youngsters, the Netherlands scores in the higher echelons'*³⁷⁸

The report pointed out that drug consumption in the Netherlands is low, with the exception of ecstasy. In the management of health risks and reduction of harm to individuals, the policies have been fairly successful. There has also been a perceptible decline in property crime, which can be partly attributable to the decline in numbers and criminality of problematic drug users

The report finishes with the assertion

*'...that Dutch drug policy has been reasonably successful, even by today's standards, in achieving the goals set out, although certain problems continually require renewed attention'*³⁷⁹

An outside observer, Malinowska-Sempruch (2013),³⁸⁰ asked:

'Why has the Netherlands, a country sometimes viewed as having a permissive approach to drugs, had better results than so many governments with much more strict policies? The country has virtually eliminated injecting drug use as a transmission of HIV and enjoys the lowest rate of problem drug use in Europe.'

To summarise the drug situation in the Netherlands; in the 1960's, the years of 'flower power' and youth emancipation, the position of the government was *'they going to do drugs anyway, so let's make it as safe as possible.'* Thus started the 'coffee-shop' concept in which young people could smoke their cannabis, under controlled and regulated conditions, but in peace, undisturbed by the police. The belief was that then they would not want to try hard drugs, if their need was satisfied by soft ones. And so it turned out. Linked to that was an ethic of tolerance, rather than punishment and the handling of drug policy by health and not by legal authorities.

Harm reduction was initiated soon after, with clean needle schemes, pre-rave drug testing and Drug Consumption Rooms for addicts where they could indulge safely.

The result has been a higher than the European average for soft drug taking, but significantly lower rates for hard drug usage, low drug-related death rate, problematic drug users and drug-related crime so that now there is a very low imprisonment rate, and several prisons have closed.

³⁷⁸ van Laar & van Ooyen-Houben (2009) *ibid* p26

³⁷⁹ van Laar & van Ooyen-Houben (2009) *ibid* p 34

³⁸⁰ Malinowska-Sempruch K (2013) *For a Safe and Effective Drug Policy, Look to the Dutch*

Professor Kasia Malinowska-Sempruch was the Director of the Open Society Global Drug Policy program. She now works in Poland. www.opensocietyfoundations.org/.../safe-and-effective-drug-policy

4.4 Germany

Germany with 80.5 million inhabitants has the largest population in Europe. It has the highest Gross Domestic Product per capita in purchasing power standards, (France is second and the UK third), 25% above the European average.³⁸¹ It is politically divided into sixteen Provinces ‘*Laender*’ each with its own legislative assembly subordinate to the federal national assembly in the capital in Berlin.

These facts are relevant to the drug situation in the country as a whole, for with the relative lack of poverty, a lower than average level of drug taking would be expected³⁸². Moreover with each of the Provinces able to pass their own laws and empowered to interpret federal law differently, it will be seen that Drug Policy varies quite considerably over the country as a whole.

Furthermore the people in the Northern Provinces have mainly Lutheranism as their religious inclination, and are more liberal in outlook in many ways and towards the matter of drug taking; whereas the Southern Provinces being mainly Catholic have a more traditional attitude toward it.

4.4.1 The ‘*geringe Menge*’ concept

In 1992 Federal Legislation introduced a measure of drug offence decriminalisation as follows: if there is no public interest in prosecution and the offender’s guilt can be considered minor, then the prosecutor may dismiss a case. The definition of ‘minor’ is the crucial concept of a ‘small amount’ (*geringe Menge*) of the drug, the precise amount being undefined by the law.³⁸³

This ruling was followed by an amendment in 1994 that criminal cases involving the procurement, supply or possession of small amounts of cannabis for personal use must be dismissed,

*‘...because both the guilt of the offender and the harm caused have to be considered trivial.’*³⁸⁴ (the ‘*ultima ratio*’)

The result was the wide variability of prosecution, and estimation of what is considered a ‘small amount’. Thus in Schleswig-Holstein and Berlin 90% of cases were dismissed whereas in Bavaria it was only 30%. Likewise the understanding of what is understood as a small amount varies widely from 30 grammes in Schleswig-Holstein, the most northerly province, to 10-15g in middle Germany and only 6g in Bavaria the most southern province*.

Attempts to regularise this situation by completely decriminalising cannabis are made from time to time in the German Parliament.³⁸⁵

³⁸¹ Wikipedia: *Germany* en.wikipedia.org/wiki/Germany

³⁸² Stevens (2011) *ibid* Chapter 2: *Afflictions of Inequality: the social distribution of drug use, dependence and related harms*

³⁸³ Paoli L & Schafer C (2013) *Cannabis Non-Prosecution Policies in Germany*.page 1. Max Planck Institute for Foreign and International Criminal Law
www.mpicc.de/ww/en/pub/forschung/forschungsarbeit/.../cannabis.htm

³⁸⁴ Jareborg N (2013) *Criminalisation as last resort*
Moritzlaw.osu.edu/students/groups/osjcl/.../Jareborg-PDF-3-17-05.pdf
the principle of ‘ultima ratio’, or ‘Criminalisation as the Last Resort’.It requires consideration of the following matters when considering an offence: (1)blameworthiness,(2)need to punish, (3)moderation (4)inefficiency, (5)costs,(6) victim’s interests.

* 30 grammes is a small pudding plateful or 13 desert spoons full. From 1g an inexperienced person will get six smokes and an experienced one will get three smokes

³⁸⁵Deutsche Welle(2010) *Germany’s almost legal drug: cannabis*.
www.dw.de/germanys-almost-legal-drug-cannabis/a-6141694

4.4.2. Education and Harm Reduction

Health care policy related to drug usage was initiated in 1991 with school age education.³⁸⁶ Emphasis was placed upon vulnerable children, those from disadvantaged or broken homes, or where children had been subjected to abuse, especially sexual, or where the parents had been drug users.³⁸⁷ Parent groups are targeted and youth clubs too. Particular weight is put upon on-line interactive methods directed at teenagers who want to reduce their cannabis consumption or give it up altogether.³⁸⁸

Harm reduction for addicts is mainly through ‘harm reduction rooms’ and needle exchange facilities. There were twenty three ‘harm reduction rooms’ in Germany’s major cities in 2011³⁸⁹ with three in Hamburg alone and one and a mobile one in Berlin. They are designated for high risk drug users and for those injecting in the open, causing a public nuisance. Zurhold,et al(2003)³⁹⁰ describe the patients seen, the staffing required and their training and the problems encountered. Their overdose rate was 0.2% of all injections made by clients, and because of the skill of the staff the mortality was zero in the year studied. In addition the staff, sociologists with special training, were able to offer counselling on health, and hygiene, refer to internists or psychiatrists or to social services to help with housing and employment.

Needle exchange centres are established on 250 sites in Germany, which enables *two* exchanges per year for an injecting addict, whereas the recommended scaling for a regular injector would be two hundred exchanges per year. (AVERT (2003), which points out that only three countries in the world achieve that level)³⁹¹. The United Nations Office for Drugs and Crime³⁹² sets nine targets for the full cover which should be provided in an Needle Exchange Unit,^(z) though in Germany many such sites are simply needle and syringe vending machines. They work on the principle of ‘you put a dirty one in and get a clean one out’. HIV infection following intravenous drug injection is falling annually

Year	2000	2007	2008	2009	2010	2011	2012	2013
% users	12.4	6.3	5.0	3.5	3.7	4.0	3.0	3.0

Table 20 Intravenous Drug Users Annual HIV rates

Source EMCDDA Statistics³⁹³

³⁸⁶ EMCDDA (2014) *Annual Reports 2014 Germany*

³⁸⁷ Bundeszentrale für gesundheitliche Aufklärung *Kinder stark machen für ein suchtfreies Leben* (strengthen children for a drug free life)
www.kinderstarkmachen.de/.../Hintergrundtext_Kinder.

³⁸⁸ Drug.com.de *Quit the Shit – ein Beratungsprogramm. Wenn du mit dem Gedanken spielst, weniger oder gar nicht mehr zu kiffen, dann bist du hier richtig. Quit the Shit ist ein Informations- und Beratungsservice*(Quit the Shit and advice programme .If you’re thinking of doing fewer spliffs or not smoking at all, then you’ve come to the right place. Quit the Shit is the information and advice service for you.) <https://www.quit-the-shit.net/>

³⁸⁹ akzept e.V.(2011) *Drug Consumption Rooms in Germany* -
www.akzept.org/pdf/aktuel_pdf/DKR07af1Eng.pdf

³⁹⁰ Zurhold H, Degwitz P, Verthein U, Haases C, (2003) *Drug Consumption Rooms in Hamburg, Germany: Evaluation of the Effects on Harm Reduction and the Reduction of Public Nuisance*.Journal of Drug Issues 2003 33:663 <http://jod.sagepub.com>

(z)see Annex A(z) for details of the WHO recommended Drug Injecting Centre .

³⁹¹ AVERT (2003) *Needle Exchange & HIV Prevention* www.avert.org/needle-exchange.htm

³⁹² UN Office for Drugs and Crime(2008) *WHO/UNODC Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for Injecting Drug Users· Technical Guide for countries to set targets for universal access to HIV Prevention, Treatment and Care·*
apps.who.int/iris/bitstream/10665/77969/1/9789241504379_eng.pdf

³⁹³ EMCDDA (2014) *Trends in injecting drug use in Europe*

Changes in health care in respects of drug usage since 1980 have been³⁹⁴

- 1.1981. Most cases of minor drug related offences are dealt with in the civil court and are awarded a two year sentence, suspended if the offender undergoes treatment.
- 2.1992. Needle exchange started .
- 3.2000. Drug Consumption Rooms (Harm Reduction Rooms)³⁹⁵ first opened.
- 4.2009. Heroin substitution treatment initiated.
- 5.2010. Health Insurance Policies agree to fund treatment* and training for Doctors

In 2012 Germany issued a new National Strategy on Drugs and Addiction Policy³⁹⁶ which dealt with addiction to drugs, alcohol, tobacco, gambling and television; this project will comment on the first only.

In the introduction to the new strategy the Minister of Health states:

'This national Strategy on Drug and Addiction Policy puts special emphasis on addiction prevention and early intervention. With the aim of promoting a healthy lifestyle among the people of our country it demonstrates ways of approaching the use of pleasurable and addictive substances responsibly in day to day life and finding the right balance.'

The policy focuses on prevention, therapy and harm reduction, and combating drug-related criminality with information provided to schools, youth groups, parents, with particular emphasis on vulnerable people. Counselling, treatment and help in overcoming addiction is provided with medical help and support. Harm reduction measures, including the provision of drug consumption rooms and needle exchange facilities are extended. Legal measures were strengthened to reduce the supply of drugs and drug-related crimes. The policy sets out ten 'corner stones' *

Thus apart from the Health Minister's introductory remarks, nothing in the Act appeared to indicate a fresh approach to the problems of drugs and addiction. A year later the country's leading lawyers put forward their own proposals.

* unlike the UK, where the National Health Service pays for almost everything, in Germany people have to take out health insurance with the State (Allgemeine Orts Krankencasse 'AOK') or contributions will fund 'private care subject to negotiation. In 2010 however this became covered under the 'routine' category

³⁹⁴ EMCDDA (2014) *Annual Reports, Germany* *ibid*

³⁹⁵ Flensborg Avis (2015) *Fixerum er en succes: Ingen dode trods 301 overdoser* (Fixer rooms are a success; No deaths despite 301 overdoses) Flensborg Avis 28 May 2015. The article reports that since the opening in 2010 of Drug Consumption Rooms in Copenhagen, Odense and Aarhus (Denmark) 355,000 clients have visited, there have been 301 overdoses and no deaths. Proof it claims that many deaths would have occurred on the street if there hadn't been the Rooms staffed with alert medics. (I am grateful to my brother-in-law, Carl-Gustav von Samson-Himmelstjerna for drawing my attention to this article and giving me a translation from the Danish.)

³⁹⁶ Die Drogenbeauftragte der Bundesregierung (2012) *National Strategy on Drugs and Addiction* (Nationale Strategie zur Drogen- und Suchtpolitik) www.drogenbeauftragte.de/.../Nationale_Strategie_Druckfassung_EN.pdf...

*The 10 'Corner Stones'

- (1) focus upon the person with help tailored to the individual's needs
- (2) prevention and health promotion targeted at schools and high risk youngsters
- (3) early intervention at the pre-addiction stage,
- (4) reaching people at the workplace, clubs, GP's surgeries,
- (5) integration of professional services
- (6) gender awareness of the different needs and especially women when pregnant, (7) targeted research,
- (8) evaluation of procedures
- (9) legal examination of New Psychoactive Substances,
- (10) support to self help and voluntary groups.

4.4.3 The *Schildow* Resolution*

In 2013 the ‘Schildow Circle’ of one hundred and twenty two University Professors of Law submitted the Schildow Resolution to the German Parliament.³⁹⁷ This states in its introductory statement that prohibition of drugs has *failed, is harmful to society and is uneconomic.* (*Die strafrechtliche Drogenprohibition ist gescheitert, sozialschaedlich und unoekonomisch.*)

It goes on to explain the thesis thus:

With prohibition the state has given up its control over the use and purity of drugs. It is not the effects of the drugs themselves that cause the problems but rather that the politics of repression of drugs that generates the problems. The overwhelming majority of drug users live a normal life, and addicts often remain socially well integrated. People with problems though need help. The legal processes have failed them, and for all others have brought only negative consequences.

The aim of prohibition is not achieved: it is meant to hinder the use of dangerous drugs. In reality this objective can never be achieved as has been shown by all the relevant scientific studies. Prohibition may scare a few people off drugs, but it impairs the dissemination of information about them, and dramatically increases the health and social harms to those people who don't want to live without them.

Prohibition is harmful for society: it causes criminality and a black market. It infringes peoples' human rights and corrupts the law. International drug cartels have the potential to destroy civil society. The enormous profits from drugs initiate wars between the cartels and the national police and military eroding the foundations of States. Prohibition is having a disastrous effect upon developing countries, impairing development of their health services.

Prohibition has limitless cost with citizens becoming the victims of economic criminality. Every year billions are spent on sentencing and incarceration of offenders, which could be better spent on prevention, care and treatment.

Prohibition harms drug users: they are discriminated against, pursued by the law and forced into a career of criminality. Drug usage is a ‘victimless crime’, penalizing especially the underprivileged and immigrants. The law doesn't protect the user and provides no protection for youth; on the contrary dangerous drug usage is exacerbated and consumers' risk of dangerous diseases, is increased. The normal experimentation with drugs by youngsters becomes criminalised, and getting out of that phase becomes more difficult. Young people become stigmatised and their opportunities in life reduced.

In Summary: the State has no right to harm the citizen through its Drug Policy; it is therefore necessary to examine and overhaul it and to assess scientifically its objectives and the harms it causes.

We as the State's teachers of the Law feel ourselves especially responsible for upholding the principles and theory of the law, and for the States holding back from interfering with the application of the ‘*ultima ratio*’* principle. Therefore we appeal to the German Parliament, not simply to the political parties in it, but to individual members and their own sense of responsibility.***

* This paraphrase is given in detail because it exemplifies my own views on what the policy should be

³⁹⁷ Schildower Kreis (Schildow Circle) (2013) *Resolution deutscher Strafrechtsprofessorinnen und Professoren an die Abgeordneten des Deutschen Bundestages* (Resolution of the Professors of Law to the Members of the German Parliament.)

http://www.schildower-kreis.de/themen/Resolution_deutscher_Strafrechtsprofessorinnen_und_professoren_an_die_Abgeordneten_des_Deutschen_Bundestages

* *ultima ratio*: criminalisation as a last resort.

*** The resolution has not yet been debated in Parliament; my emails to the Schildow secretariat have gone unanswered.

In 2009 the first cannabis ‘coffee shop’ in Germany was opened in Hamburg³⁹⁸ the ‘Araba Lounge’, in the Sternschanze district.* The proprietor commented on the difficulty he had in getting the licence which stipulated it had to be not in the vicinity of schools, children’s nurseries or libraries. Berlin too plans coffee shops, where the mayor of the Kreuzberg district plans to open a coffee shop, with trained staff, to local residents above the age of eighteen.³⁹⁹ The impetus for this is that the Gorkitz Park in the district has become a disreputable site for drug traffickers and users, dangerous and unpleasant for the families and children who also wish to relax there.

The District Council agreed and the matter was passed to the regional parliament for approval⁴⁰⁰ which was gained two months later⁴⁰¹. The mayor of Kreuzberg now seeks approval for controlled sale of cannabis.⁴⁰² She has been met however with considerable opposition. The town council of Kreuzberg is still involved in discussions,⁴⁰³ not all favourable,⁴⁰⁴ but the matter is still actively being discussed in the Press.⁴⁰⁵

Other places in Germany where coffee shops have opened in the last year are Kassel, Bamberg, Nuremberg, Cologne and Augsburg.⁴⁰⁶ In his local newspaper Theis (2014) wrote that with all the excitement about coffee shops, he recalled that in Holland cannabis consumption is little more there than it is here in Augsburg; moreover in Holland because young people can get cannabis easily they are not tempted by the Internet’s ‘new psychoactive substances’ of unknown potential harm.⁴⁰⁷ &⁴⁰⁸

To summarise the state of health care and drug policy in Germany at the present date; decriminalisation of cannabis use has been long accepted within the concept of personal possession of *geringe Menge*, that is ‘small amounts.’ Health education has been a prime feature of drug policy. Implementation of drug policy is in the hands of the health and not legal authorities. Risk reduction is seen in the establishment of a small number of ‘coffee-

* see Annex C Acknowledgements .One of my supervisors went to look for the Araba Lounge...

³⁹⁸ Die Hanfplantage (2009) *Erster Coffeeshop in Hamburg eröffnet* (first coffee shop in Hamburg opened)
www.hanfplantage.de/erster-coffeeshop-in-hamburg-e...

³⁹⁹ Roth A-L & Termieden H (2013) *Drogenhandel im Görlitzer Park: Grüne wollen coffeeshop* (Drug trading in the Gorkitz Park: the Greens want a coffee shop) Spiegel on Line 11 Sept 2013
www.spiegel.de › Panorama › Gesellschaft › Marihuana

⁴⁰⁰ Roth A-L & Termieden H (2013) *Grünen-Projekt in Berlin: Bezirksparlament stimmt für Coffeeshop im Görlitzer Park* (The Greens’ project in Berlin: District Council supports a coffee shop in Gorkitz Park) Spiegel on Line 28 November 2013

⁴⁰¹ PI News(2013) *Kreuzberg kriegts Deutschlands ersten Coffeeshop* (Kreuzberg gets Germany’s first coffee shop)
www.pi-news.net/2013/.../kreuzberg-kriegts-deutschlands-ersten-coffeeshop

⁴⁰² Von Unger T (2014) *Kann hier bald jeder legal Cannabis kaufen?* (Could anyone soon buy cannabis legally here?) Berlin Abendblatt 8 June 2014
www.abendblatt-berlin.de/2014/.../kann-hier-bald-jeder-legal-cannabis-kaufen?

⁴⁰³ Schucker C (2014) *Workshop discussed coffee shops plans* Tagesspiegel 17 Oct 2014
<http://www.tagesspiegel.de/berlin/bezirke/kreuzberg-blog/drogen-in-berlin-kreuzberg-monika-herrmann-noch-2014-antrag-auf-coffeeshops/10684198.html>.

⁴⁰⁴ DiskursKorrekt(2014) *Nachrichten aus dem Irrenhaus* (News from the madhouse) 11 Nov 14
diskurskorrekt.wordpress.com/.../nachrichten-aus-dem-irrenhaus

⁴⁰⁵ Pham K & Kuhn K (2015) *Cannabis: Zeit, was zu drehen* (Time for a change) Die Zeit Newspaper 23 January 2015 www.zeit.de › ... › Jahrgang: 2015 › Ausgabe: 04 -

⁴⁰⁶ rbb Rundfunk Berlin (2014) *"Verkaufs-Shop" oder "Kifferhöhle"?* (Honest shop or spliffer hell?) .
www.rbb-online.de/politik/beitrag/2014/.../kreuzberger-coffee-shop.html

⁴⁰⁷ Theis L (2014) *Kommentar von Lea Thies: Warum Cannabis legal sein sollte ...* (Commentary from Lea Theis: why cannabis should be legal) Augsburger Allgemeine 22 July 2014 www.augsburger-allgemeine.de

⁴⁰⁸ Sternberg J (2014) Kieler Nachrichtenblatt (Kiel Newspaper) 6 December 2014 *Kampagne wirbt im Kino für Legalisierung von Cannabis* (the campaign for legalisation of cannabis advertised in the cinema) NB it is forbidden to advertise on the TV

shops.’ Harm reduction in the use of a needle exchange programme, drug consumption rooms and drug injecting centres. Methadone replacement therapy is well established and Heroin Assisted Therapy trials started in 2009.

The major project of drug policy reform proposed by the Schildower Resolution, initiated by 122 Professors of Law in 2013 and submitted to the German Parliament has not yet been debated there.

4.5 Switzerland

Switzerland’s achievements in the drug scene are well known, for it, more than any other European country furthered the concept of *harm reduction*, in contrast to prohibition. Previously it had been regarded as a matter for prohibition by policing, and for those afflicted, abstinence was the aim. If that failed abandonment of the ‘patient’ was the only action to be taken.

Then Mino* and Arsever understood it differently:

*“.....after all, he who ventures beyond the pale must always pay the price for his folly by suffering. Well, that was our attitude and we didn’t worry about what our patients felt. We literally gave up being doctors, as we gave up on alleviating human suffering.....AIDS opened our eyes”*⁴⁰⁹

The Swiss had realised that drug addiction was an illness to be prevented or avoided if possible; and if not, harm to the patient has to be reduced. Like a chronic disease, long term surveillance would be needed to anticipate relapses or complications developing. The Swiss appreciated that problematic drug users occupy a difficult and conflicted social context, often an alternative lifestyle and identity, to which the ‘other side of society’ is often intolerant.

Care and support are necessary as well as many different therapies and the Swiss were the first to introduce methadone substitution, heroin assisted therapy, syringe exchange programmes, drug consumption rooms and quality testing of illicit substances.⁴¹⁰

It was the 1960’s when the youth ‘counter-culture’ swept across Europe and into Switzerland with cannabis smoking part of it. However cannabis rarely causes much harm^(y) so it was only in the 1970’s and 1980’s when heroin supervened and injecting users were seen on the streets that the citizens complained.(aa)

* Annie Mino was at the time(1996) the Director of the Substance Abuse Service in Geneva, and wrote of her own experiences in the book.

⁴⁰⁹ Mino Annie, Arsever Sylvie (1996) *J'accuse les mensonges qui tuent les drogues* Calmann-Levy, Rouen 1 Jan 1996 www.anpaa83.asso.fr/fiche_livre.php?compteur=1

Dans cet ouvrage, les auteurs "accusent" les specialistes, les hommes politiques et les journalistes de disinformation sur les effets des produits en particulier des opiaces. Elles "accusent" les gouvernements qui ont prohibe l'usage de la methadone et la distribution de seringues de "non assistance le personne en danger"; "accusent" les therapeutes d'extorsion" et les responsables de la guerre de la drogue de mener en realite une "guerre contre les drogues". L'une des auteurs, psychiatre, denonce dans ce pamphlet ces erreurs therapeutiques, et, forte de son experience genevoise, retrace pour nous les etapes qui l'ont conduite cette prise de conscience. Elle raconte et justifie sa pratique actuelle qui vise, au moyen notamment de prescription d'opiaces, et permettre " des gens gravement marginalises d'acceder la sante et un peu plus de matriise de leur propre existence". Elle espire meme en conduire certains sur le chemin de l'abstinence....

(y) see Annex A for details of the effects of cannabis

(aa) see Annex A The citizens of Zurich take action

⁴¹⁰ Buechli D S & Dreifuss R (2012) *Swiss Drug Policy in International Context – Fought, Ignored, Admired. In this paper the authors, the latter was the Minister of Health at the time, recall the struggles Switzerland had with the International Drug Control Board, WHO, etc which were still fixated on 'prohibition' being the only way to control the drug trade.*
www.lse.ac.uk/IDEAS/publications/reports/pdf/.../Buechli-Dreifuss.pdf

However it was the soaring HIV rates resulting from injecting, the highest rates in Western Europe, which alarmed the public in the late 1980s and early 1990s. Up to 1,000 drug users would gather daily in Zurich's infamous Spitzplatz^(aa) park, referred to as the 'needle park,' for open air drug trafficking and taking.⁴¹¹ Professor Grob of the University of Zurich and Dr Seidenberg a local practitioner defied the law of 1975, which forbade the provision of clean needles and syringes, to set up a clinic in the middle of the crowd there. Meili(2007)⁴¹² dramatically recalls his experiences. Threats of prosecution by the city authorities were withdrawn following a petition from three hundred clinicians.

4.5.1 The ZIPP project

In 1988 there was initiated the ZIPP Project (*Züricher Intervention Pilot Project: Aids für Drogengefährdete und Drogenabhängige* (help for those threatened by drugs or dependent upon drugs)), which initiated drop-in and treatment centres, drug-user centres for safe injecting, needle and syringe exchange facilities (10 million syringes were dispensed between 1988-1992), vaccination for Hepatitis B, housing and employment programmes, and public health supervision. This was the precursor to the 'Four Pillar Policy' of the future. Support was provided by the Minister for the Interior, Ruth Dreifuss, later the first woman President of Switzerland.⁴¹³ Another pilot scheme was known as 'ProMedDro (*Programme de mesures de sante de la Confédération en vue de résoudre les problèmes de drogue*)' which lasted from 1991-2002. The objects of the ProMedDro programme were to decrease the numbers of new drug users, prevent people from becoming dependent, help them overcome addiction through therapy and social integration, and to improve the health and living conditions of drug users.⁴¹⁴

4.5.2 The HAT project

This was a trial of Heroin Assisted Therapy^(r) for one thousand severely dependent addicts who had failed to respond to other treatment programmes; it was evaluated from 1994-6 and the project Report showed that⁴¹⁵ *Many patients' health, social and employment situation much improved. No deaths from overdose occurred. Stabilisation on heroin achieved in three months; no increase of dose needed*

40% moved into methadone therapy

25% became abstinent.

Criminal activity decreased by 60%, social contacts being 'drug free'.

Heroin from the trial did not find its way on to illicit markets

⁴¹¹ Nebehay S (2010) *Swiss drug policy should serve as model: experts* / Reuters 25 Oct 2010

www.reuters.com/article/.../us-swiss-drugs-idUSTRE69O3VI20101025

⁴¹² Meili D (2007) *Vom Zürcher Spitzplatz zur Heroinvverschreibung* (from Zurich's Spitzplatz to heroin prescriptions.)

www.arud.ch/.../2007_Meili_VomSpitzplatzzurHeroinVerschreibung

⁴¹³ Csete J (2010) *From the Mountains What the World Can Learn from. Drug Policy Changes in Switzerland* (at Annex A(aa) there is a summary of this article.

www.countthecosts.org/sites/default/files/From_the_Mountains.pdf

⁴¹⁴ Collin C (2002) *Switzerland's Drug Policy* p2

www.parl.gc.ca/Content/SEN/Committee/371/ille/library/collin1-e.htm

(r) see Annex A which describes how Dr Marks first had the idea and was reviled for it

* to start of with patients got as much heroin as they wanted. They soon stabilised on what they needed and then started to respond to therapy and returned to normal life. It was postulated that their previous overriding need had been to secure a resupply of the drug for the next 'fix'. Once that had been provided for with the availability of a limitless supply, they could settle down to sorting out the underlying psychological problems which had generated the addiction in the first place

⁴¹⁵ Csete J (2010) *ibid* p...

Other countries undertaking such trials were Netherlands, Spain, Germany, Canada and England,⁴¹⁶ and the comments were made that the costs of supervised injection of heroin (between E12,700 and E20,400/year) were higher than with methadone (E1,600-E3,500/year). But this was compensated for by the significant savings to society, in particular a greater reduction in the costs of criminal behaviour procedures and imprisonment.⁴¹⁷ This might well be due as much to the supervision and support given during the injecting sessions, as to the nature of the substance used.

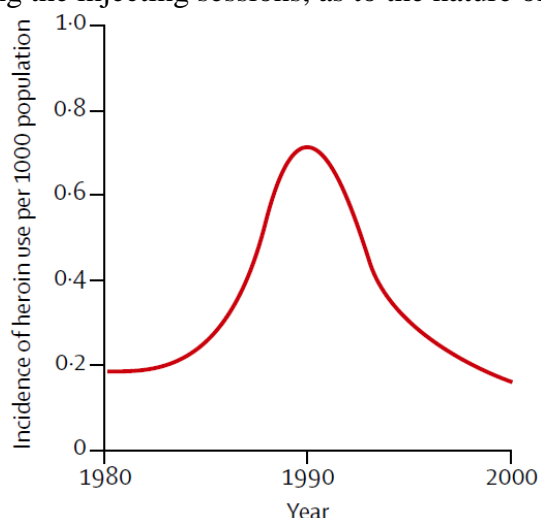


Table 21 Heroin users in Zurich 1980-2000 during the period of the ‘needle park’

Courtesy of Suchtmonitoring in der Schweiz 2014, Bundesamt für Gesundheit

Taken from Nordt C & Stohler R (2006)⁴¹⁸

The reduction in heroin usage was matched by improvement in the health of users through the implementation of the policy of harm reduction from the time of the ‘needle park’ onwards.

Life-time usage of heroin amongst younger people fell too, but for older people the figures rose; thus younger people were not starting, and the youth of the past was getting older:

Year	1992	1997	2002	2007	2012
15-39 year olds	1.3%	1.0%	0.9%	0.9%	0.7%
40+ year olds	nk	0.1%	0.3%	0.6%	0.8%

Table 22 Heroin usage by younger people

Courtesy of Suchtmonitoring in der Schweiz 2014, Bundesamt für Gesundheit

Other trends were also positive with falls in numbers of drug dependants as well as a rising age of those in treatment:

Year	1992	2002	2012
Heroin dependent	30,000	26,000	
Median age for those in treatment	26.5 (1994)	30.5 (2006)	

Table 23 Heroin Dependence Source Swiss Federal Office of Public Health⁴¹⁹

⁴¹⁶ Strang J, Groschka T, Metrebian N, (2012) *EMCDDA INSIGHTS 11, New heroin-assisted drug treatment. Recent evidence and current practice of supervised injecting heroin treatment in Europe and beyond*.

[www.researchgate.net/.../262796947_EMCDDA_INSIGHTS_11_New_heroin assisted drug treatment](http://www.researchgate.net/.../262796947_EMCDDA_INSIGHTS_11_New_heroin_assisted_drug_treatment).

See also Annex A(r) where the efforts of Dr John Marks in the 1980's to carry out a heroin replacement therapy clinic in Britain, attracted opprobrium from the medical and political establishment, which forced it to close. Fortunately however not before Professor Uchterberger of Zurich had studied Dr Marks' methods and started the trials which led to the HAT programmes now widespread throughout Europe.

⁴¹⁷ Strang et al (2012) *ibid* p13

⁴¹⁸ Nordt C & Stohler R (2006) *Incidence of heroin use in Switzerland* *Lancet* 367(9525) pp1830-1834

Death rates too showed significant falls

	1980	1985	1990	1995	2000	2005
Deaths due to drug use	80	120	280	360	200	170
Deaths due to HIV through injecting	0	10	120	280	50	40

Table 24 Falling Death Rates

Peak death rate was in 1992 at 410 and AIDS deaths in 1994 was 340

Source: Beckley Foundation⁴²⁰

Young people in Switzerland these days do not use hard drugs as much as they used to do, for drug taking is considered now to be a *medical* problem, an illness and not a police matter any more, and the challenge and excitement has rather gone out of it. Then there is the concept of 'Musto's Generational Theory'⁴²¹. Nordt & Stohler⁴²² felt that the reason might be more a social learning effect whereby the next generation does not like to use heroin for it has seen the former generation go from early pleasant experiences to devastating circumstances for addicts and their families. It might however also be said that the decrease in heroin taking by young people might just be due to the improved health teaching nowadays.

Suchtmonitoring in der Schweiz (2014)⁴²³ makes the point, that cannabis consumption has increased for young people it has lost the stigma of being a drug, regarded by most as are alcohol and smoking.

The Swiss 'Harm Reduction Policy' started in 1994. Public opinion had changed from the belief in prohibition, intolerance of 'alternative lifestyles' and insistence on abstinence as a precondition of treatment, to a more pragmatic approach of harm reduction and help for those afflicted into rehabilitation⁴²⁴.

4.5.3 The Four Pillar Policy

It became known as the 'Four Pillar Policy'⁴²⁵ & ⁴²⁶ and acknowledged that complete prevention through prohibition could never be achieved, but what could be attained was the reduction of harm to individuals and society through

1. Prevention

To promote the avoidance of drugs especially amongst children and youth, to prevent people moving from casual drug use to harmful use and addiction and from less dangerous to more harmful drugs.

2. Treatment

To help addicts break the habit, improve their mental and physical health and to encourage social reintegration.

3. Harm reduction

⁴¹⁹ Swiss Federal Office of Public Health 2009 & 2012

www.bag.admin.ch/themen/drogen/00042/00624/06044/07683/index.html

⁴²⁰ Savory J-F, Hallam C & Bewley-Taylor D *The Swiss Four Pillars Policy: An Evolution from Local Experimentation to Federal Law* The Beckley Foundation Drug Policy Programme
http://www.beckleyfoundation.org/pdf/Briefingpaper_18.pdf

⁴²¹ Codrington G (2008) *Musto's Generational Theory*. This in essence suggests that the younger generation will always reject the mores of the older generation
www.tomorrowtoday_uk_com/articles/article001_intro_gens_hm.

⁴²² Nordt C & Stohler R (2006) *ibid*

⁴²³ *Suchtmonitoring in der Schweiz* (2014) (Drug Monitoring in Switzerland Annual Report)

⁴²⁴ Savory et al *ibid* p3-4

⁴²⁵ Collin (2002) *ibid* pp 3 & 4

⁴²⁶ City of Vancouver (2012) *Four Pillars drug strategy* describes how the policy introduced there in 2005 is also successfully used in Geneva, Zurich, Frankfurt and Sydney
vancouver.ca > ... > Mental health and addiction > Drugs

To reduce the harm of addiction and the spread of illness; providing needle exchange and safe injection rooms, support and consultation for addicts and encouragement with housing and employment. Support for prostitutes earning for their drug habit, and support to children of drug dependent parents.

4. Enforcement.

Vigorous pursuit of traffickers, suppliers and organised crime involved in the illegal drugs trade. Users not now to be the principal targets of police attention.

The Four Pillar Policy was audited in 1989, 1996 and 1999 with recommended improvements.⁴²⁷ They advised that there should be no penalties for possession of small quantities of drugs for personal use, and that cannabis should be accepted legally, regarded socially as is alcohol. These proposals on partial decriminalisation were accepted by the government, but challenged and rejected by referenda. However after almost twenty years of debate it became law in 2008.

The Four Pillar Policy it has been so effective that Switzerland proposed to the United Nations for the General Assembly Special Session 2016, that the Four Pillar Policy should be implemented worldwide.⁴²⁸ It submitted that to improve public health, emphasis has to be placed on prevention, harm-reducing measures and treatment programmes for addicts.⁴²⁹ It also pointed out that illegality always results in uncontrollability of substances and consumption which constitutes the greatest risk to the user. It concluded that :

*'The political establishment is responsible for ensuring the safety and health of its citizens. If it accepts the social reality that people do use drugs, it must also arrange for appropriate monitoring of these products. Ensuing safety with ongoing illegality of these substances is impossible'*⁴³⁰

Thus clearly making the point that if the health of the citizen is to be made as safe as possible the state has the *duty* to ensure that the drugs the citizens take are safe too. This can only be achieved if they pass legally through the hands of the state

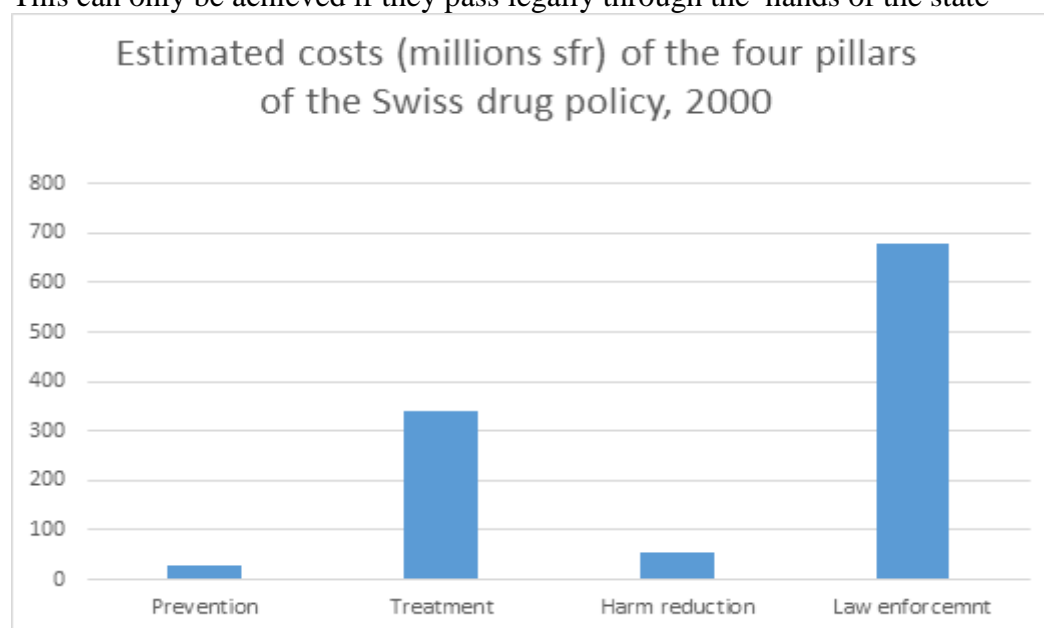


Table 25 Costs of the Four Pillar Policy in Switzerland

Source Verena Maag⁴³¹

⁴²⁷ Collin(2002) ibid pp9-14

⁴²⁸ Berthel T (...) for the Swiss Federal Commission for Drug Issues· *Position of the EKDF (Swiss Federal Commission for Drug Issues)* in connection with the Special Session of the UN General Assembly on Drug Issues to take place in 2016 www.bag.admin.ch/themen/drogen/00042/00624/.../index.html?...

⁴²⁹ Ibid para 4.1,p 6

⁴³⁰ Ibid para 2.1, p 3

⁴³¹ Verena Maag (2014) Bundesamt für Gesundheit (Ministry of Health), Bern. *Personal communication*

The chart shows that the Four Pillar Policy has as its weakness the fact that the funding in extremely unequal. This in part is due to the pressure from international drug cartels importing illegal drugs into the country.¹⁰¹

4.5.4 Other Psychoactive Drugs

Other psychoactive drugs (with the exception of cannabis) are mentioned in the Annual Report on drugs of Addiction, but are stated; ‘to never have great importance in Switzerland’⁴³², as shown in the chart:

	Cocaine*	amphetamine	ecstasy	magic mushrooms	LSD	ketamine
Lifetime taking	3.0%	2.2%	2.7%	3.2%	0.69%	0.03
Last 12 months	0.5%	0.3%	0.2%	nk	nk	nk
Last 30 days	0.1%	0.1%	0.0%	nk	nk	nk
Mortality	total 3	total 5	0	0	0	0
	(in years 2007-11)	(in years 1995-2011)			(nk: not known)	

Table 26 Other psychoactive drugs used

Source: Suchtmonitoring in der Schweiz 2014, Bundesamt für der Gesundheit

4.5.5 Cannabis

Lifetime (15 to 64 years) cannabis once-in-a-lifetime experience, as a percentage of the population, in Switzerland is generally flat: 2011: 27.9%, 2012: 29.6%, 2013 29.0%. Regular cannabis smoking is similar: in 1997 3.4% of the population were occasional smokers and in 2013 the figure was 2.7%. Problem smokers, defined as those who smoke on more than ten days a month are 1.3% of the population or 56.7% of smokers. Admissions to hospital through cannabis intoxication is 1.5/100,000, little changed over the years, and the total death rate known to the Swiss Health Ministry is one person only.

The age of starting cannabis smoking is falling slightly: in 2004 it averaged 17.8 years of age, in 2008: 17.0, and in 2002 it was 16.8. On the other hand school children’s experience shows a downwards trend:

	2004	2007	2010
never tried it	53.9%	56.5%	59.0%
once tried it	32.8%	32.3%	30.5%
recently tried it	13.3%	11.1%	10.4%

Table 27 Cannabis and School children

Source Suchtmonitoring in der Schweiz 2014, Bundesamt für der Gesundheit

Cannabis is considered by most people as no worse than alcohol or cigarettes. In fact in the Annual Report on Drugs of Addiction, they are put *before* ‘illegal’ recreational drugs in the index of dangerous drugs^{433*}

⁴³² Suchtmonitoring (2014) *ibid* at section: Kokain; Markt und Regalierungen

* crack nil usage recorded up to 2013

A recently introduced measure is the purity testing of drugs at dance halls and raves .

During the years of passage of the Four Pillar Policy through Parliament, attempts were made to decriminalise cannabis. These failed because the attention of the public was on the Four Pillar Policy and the issue of cannabis was no longer considered to be a significant problem⁴³⁴. In recent times however measures of decriminalisation have taken place and still are progressing. Arrest for possession has been replaced with an on-the-spot fine of SF 100 if the possessor has less than 10g; this has been introduced mainly to avoid some 30,000 cases annually of possession blocking up the courts, at the same time bringing about large savings in costs⁴³⁵.

Several Cantons** authorised the growing of up to four cannabis plants⁴³⁶ but this was invalidated by order of the Federal Court.⁴³⁷ Home grown cannabis, though technically illegal, is the source for 8.7% of 15-29 year old smokers.⁴³⁸ 'Coffee Shops', as in the Netherlands, do not exist in Switzerland, but it is anticipated that they may start soon as a pilot project.⁴³⁹

4.5.6 Summary

Health officials in Switzerland realised early on that drug addiction was a chronic illness requiring proper treatment. Methadone substitution and heroin assisted therapy together with widely disseminated needle exchange schemes have brought about a significant reduction in illness in the population as a whole. There has been a satisfactory fall in the infection and death rates of users too. Other drugs, cannabis excepted are used very little.

The 'Four Pillar Policy' (prevention, treatment, harm reduction and enforcement) is now used as an exemplar for several other countries. Moves are afoot to allow cannabis possession for personal consumption, the private growing of it and the establishment of coffee-shops.

*Smoking related deaths 15% of all deaths, alcohol related deaths (excluding accidents) 8% all deaths(2011)

** These were Vaud, Neuchatel, Geneva, Fribourg, Basel and Ticino

⁴³⁴ Savory et al ibid p 9

⁴³⁵ Withnall A (2013) *Switzerland changes law to decriminalise marijuana* .
The Independent 23Nov2013
www.independent.co.uk › News › World › Europe

⁴³⁶ Sparks I (2011) *Swiss cannabis smokers to be allowed to grow four marijuana plants*
Daily Mail 17Nov2011
www.dailymail.co.uk/.../Swiss-cannabis-smokers-allowed-grow-marijuana

⁴³⁷ Wikipedia(2012) *Cannabis in Switzerland*
en.wikipedia.org/wiki/Cannabis_in_Switzerland

⁴³⁸ Suchtmonitoring (2014) ibid *Cannabis* Source of Cannabis is: home grown 8.7%, given by friends 57.7%, bought from a friend 33.6%, bought in a shop 5.8% bought in the street 23.0%

⁴³⁹ United Nations Drug Control(2014) *Switzerland*
www.undrugcontrol.info/en/home/tag/35-switzerland
Switzerland's cities are looking at introducing cannabis social clubs—a controversial issue. "We propose experimenting with a possible new model because we need evidence of how the black market, crime and public health would change as a result of regulation," former interior minister Ruth Dreifuss, previous President of Switzerland, and also a member of the Global Commission on Drug Policy, explained. "The pilot project will give us experience and facts so we can design a new policy."

4.6 The Czech Republic

'The Czech Republic's drug policy serves as an exemplary precedent for transforming drug policy from repression-based to evidence-based approaches'

Kasia Malinowska-Sempruch⁴⁴⁰
Director, Global Drug Policy Program

The Czech Republic's drug abuse policy came to international notice for three reasons: firstly like Portugal,^{*} it partially decriminalised recreational drugs, and before that carried out a cost-benefit analysis of not doing so, thus basing subsequent policy decisions on evidence. Secondly it has instigated a preventative programme, Europe's first accredited certified system, which has widespread support from the European Monitoring Centre for Drugs of Abuse, and thirdly the country adopted drug policies very similar to the Swiss 'Four Pillar Policy'

It was visited by the UK Parliamentary Commission, in 2013-14, on account of its progressive policies⁴⁴¹ and commented on extensively in the press^{442 & 443}.

The Czech Republic is a 'developed' country (classified by the World Bank), with an advanced high income economy, high living standards and strong democratic governance.⁴⁴⁴ The country's demographic details, in comparison with the other countries in this project are noted (bb) However the Czech Republic's individual's GDP is *lower* than the European average and *low* too is the percentage of the GDP spent on health and social care. At the same time unemployment and poverty are also low, all these perhaps having a bearing on the drug abuse scene.

Following the fall of communism in 1989, the government returned to more humane and democratic values, including a law to abolish punishment for personal possession of illegal drugs. In 1997 a proposal was submitted to parliament that criminal penalties would be *reintroduced* for possession of any amount of drugs. To counter this another law was introduced that criminalisation would only apply in the event that the amount of drugs being carried by a person was '*larger than small*'.^{*} This law was vetoed by the President of the Republic, but his veto was overturned by Parliament and the matter was provisionally passed into law.

However first Parliament ordered Czech National Drugs Commission to audit the new law from 1999-2001, to ascertain the effects of criminalisation as against decriminalisation, and address five hypotheses which had been put forward by the parliamentarians, namely:

^{*} other countries which have partially decriminalised are the Netherlands, Belgium, Spain, Estonia, Canada, Argentina, Brazil, Peru, Mexico and Uruguay

(bb) Population and Demographic Comparisons at Annex A

⁴⁴⁰ Malinowska-Sempruch K (2012) in Csete J (2012) *A Balancing Act: Policymaking on Illicit Drugs in the Czech Republic* (published by Open Society Foundations ISBN:978-1-936133-65-9)

⁴⁴¹ House of Commons debate
www.publications.parliament.uk/pa/cm201415/cmhansard/cm141030/debtext/141030-0002.htm#14103037000001

⁴⁴² Travis A 2014 *Eleven countries studied one inescapable conclusion-the drug laws don't work*
Also editorial: *Official: Tough or Tender, drugs policy does affect the amount of drug abuse. But tough costs more* Guardian Newspaper 30 October 2014

⁴⁴³ Murkin G 2014 *The public mood is changing on drugs, claim MPs determined to reform laws*
Also editorial *This opportunity for reform must not be wasted* The Independent 30 October 2014

⁴⁴⁴ Wikipedia. *The Czech Republic* en.wikipedia.org/wiki/Czech_Republic

^{*} The comparison here is with the '*geringe Menge*' (little amount) which a person is allowed to carry without infringing the law in Germany

1. After the introduction of a penalty for possession, availability of drugs would decrease
2. Number of new drug takers would decrease
3. Incidence of new users would decrease
4. Health generally would improve
5. Social costs would not increase

Table 28 The Five Hypotheses ⁴⁴⁵

Source Csete(2012)

The report on this 'Impact Analysis Project of the New Drug Legislation', concluded that the implementation of a penalty for possession for personal use did *not* meet any of the tested objectives. ^{446&447}

The findings of the Project were

<p>The availability of drugs did <i>not</i> decline</p> <p>The number of drug users <i>increased</i></p> <p>The numbers of new users <i>increased</i></p> <p>Adverse health events related to drug taking <i>increased</i></p> <p>There was a <i>high social and financial cost</i></p>

Table 29 The findings of the Project

Source Csete (2012)

The effects of enforcement of such a policy (through police, court, and prison costs, as well as loss of earnings for the imprisoned subject),

'brought about avoidable costs that made the society ineffectively expend resources that could have been used for better purposes-of an amount of at least CSK37million' ⁴⁴⁸(bb)

This was noticed in the UK Parliament and the European Union Select Committee observed that this evaluation had taken place and that during the two years of enforcement of criminalisation of possession of drugs for personal use:

...the availability and use of drugs increased, as did the numbers of new drug users. Furthermore, the social costs of illicit drug use also increased significantly. In 2010 the Czech Republic, partly on the basis of this evidence, formally decriminalised possession of illegal drugs for personal use' ⁴⁴⁹

(bb) see Annex A Impact Analysis Project of New Drugs Legislation for further details

⁴⁴⁵ Csete J (2012) A Balancing Act; *Polymaking on Illicit Drugs in the Czech Republic* (published by Open Society Foundations ISBN:978-1-936133-65-9) At page 19-23 Professor Csete outlines the political machinations which led up to the establishment of the Impact Analysis Project .At one time an anti-Government opposition was formed by an unlikely coalition of the Christian Democrats(who believed drug taking to be contrary to Scripture) and the Communists (who had a nostalgic longing for the ideological control of peoples' morality.)

⁴⁴⁶ Zabransky T, Mravcik V, Gajdosikova H, Miovsu M (2001) *Impact Analysis Project of New Drugs Legislation* for the Secretariat of the National Drug Commission Office of the Czech Government (with statistical and epidemiological advice and assistance from Florida University and the Open Society Institute, New York)

www.druglawreform.info/.../787-impact-analysis-project-of-new-drugs-legislation.

⁴⁴⁷ Csete J(2012)ibid p22 . Professor Csete mentions several reservations which did not however materially affect the outcome of the Project

⁴⁴⁸ Zabransky et al (2001) ibid Section 5

⁴⁴⁹ The House of Lords - Lords Select Committees *The EU Drugs Strategy European Union Reports* page 15, para 34

www.publications.parliament.uk > ... >

4.6.1 Greater-than-small Quantities

In 2009 the 'Greater-than-Small' concept of legal possession of drugs was introduced,

Possession for Personal Use Greater-Than-Small Quantities	
Type of Substance	Quantity Greater-Than-Small
Methamphetamine	More than 2 g
Heroin	More than 1.5 g
Cocaine	More than 1 g
Cannabis	More than 15 g of dry matter
Hashish	More than 5 g
Ecstasy ⁴⁵⁰ (MDMA)	More than 4 tablets/capsules or more than 0.4 g of powdery or crystalline substance

Source: Report: *The Czech Republic – 2009 Drug Situation*.⁴⁵¹

Table 30 Greater than Small Quantities for Possession

small amounts drugs being allowed, with the police bearing down on traffickers.⁴⁵²

The penalties are severe if a person is found with more than the permitted quantity for then they are assumed to be trafficking. If the quantity is less it is considered to be for personal use, although a misdemeanour, and an unrecorded caution is given, and sometimes a fine. However the police draw a distinction between cannabis and other drugs, and deal with cannabis only by warning the person with a small quantity.⁴⁵³

Cultivation of the relevant plants is dealt with in a similar manner:

Cultivation of Plants and Mushrooms for Personal Use Greater-Than-Small Quantities	
List of Plants and Mushrooms	Quantity Greater-Than-Small
Plants of Cannabis containing more than 0.3% THC	More than 5
Plants containing DMT	More than 5
Plants containing 5-methoxy-DMT	More than 5
Plants containing Mescaline	More than 5
Coca Shrub	More than 5
Mushrooms containing Psilocybin and Psilocin	More than 40

Source: Report: *The Czech Republic – 2009 Drug Situation*. Praha: Úřad vlády České republiky.⁴⁵⁴

Table 31 Permitted Cultivation

⁴⁵⁰ Mravcik V (2003) *Evaluation of Preventative Activities on the Dance Scene: A Methodological Paper - Drogy-info.cz*. This paper describes the work of out-reach NGOs who qualitatively and quantitatively test ecstasy (known as the 'dance drug') at dances and care of people who are at risk. It is mentioned that the Institute of Pharmacology at Charles University, Prague keeps an index of recreationally used psychoactive drugs.

www.drogy-info.cz/.../annotation%20evaluation%20of%20preventive%..

⁴⁵¹ Drug War Facts *Czech Republic Data and Policies* p 10 para24 Praha: Úřad vlády České Republiky www.drugwarfacts.org > ... > European Union

⁴⁵² Cunningham B (2009) *New drug guidelines are Europe's most liberal . Czech rules on narcotics possession designed to aid law enforcement-* The Prague Post 23 December 2009

www.praguepost.cz/.../3194-new-drug-guidelines-are-europes-most-libera

⁴⁵³ Csete J (2012) *ibid* p 23 There was an attempt made to classify drugs into three groups:(1) cannabis and cannabinoids),(2) ecstasy, LSD and psilocybin mushrooms,(3) all others.The judiciary found that too difficult to administer and it was agreed that the classification would be two groups (1) cannabis and cannabinoids, which would incur mild penalties and (2)all the others which would incur severe penalties.

⁴⁵⁴ Drug War Facts (2009)*Czech Republic Data and Policies* *ibid* p 10&11 para25

With the exception of amphetamine/methyl amphetamine and cannabis, all the usage figures are better or substantially better for the Czech Republic than for the United Kingdom. Cannabis usage however amongst Czech schoolchildren (42%) is the highest in Europe, and is said to be due to the activities of Vietnamese people who have settled there recently, and are the leaders in illegal cultivation.^{455*} For people of all ages it is 9.2% (UK 6.4)

Methyl amphetamine ⁴⁵⁶ (dd) has the highest usage in Europe. It is derived from legally sold medicinal products (nasal spray, volume filler for anti-flu injection, cough medicine and other substances) from Poland usually, chemically transformed into Pervitin there where the cost price is E12 for 1g or in the Czech Republic where it retails for E20-E35 per 1g⁴⁵⁷. If exported to Germany it will sell there at E80-E120 per gram.⁴⁵⁸&⁴⁵⁹. Pervitin is in the group of drugs with the greater risk of harm (see Nutt's classification at Chapter 1), but it is no worse than the other drugs in this group,⁴⁶⁰ There are restrictions to pharmacists for a range of medicines which can be used in 'cooking' the drug.⁴⁶¹

Drug usage percentages of the population:

	Cannabis	heroin	cocaine	amphet- amine	ecstasy	LSD
life time						
15-34 years	45.9	0.7	3.7	4.5	7.2	5.4
15-64	27.9	0.6	2.3	2.3	3.6	2.8
last twelve months						
15-34	18.3	0.2	0.6	1.0	1.2	0.7
15-64	9.2	0.2	0.4	0.5	0.6	0.2
last thirty days						
15-34	8.8	0.2	0.2	0.4	0.1	0.2
15-64	4.4	0.1	0.1	0.2	0.1	0.1

Source *The Czech Republic – 2012 Drug Situation*..⁴⁶²

Table 33

Drug usage as a population percentage

⁴⁵⁵ EMCDDA (2014) Summary of the Drug Situation for the Czech Republic
www.emcdda.europa.eu › Publications › National reports › 2000

* In 2012 large scale cannabis cultivation sites seized and destroyed numbered 218 . The number of plants seized were 2010:90,091, 2011:62,817, 2012:64,904

⁴⁵⁶ Csete J (2012) *ibid* page 15 where she explains that the use of Pervitin developed during the Communist era. The state's frontiers were so successfully sealed that import of drugs of addiction was impossible. So people made their own: 'brown heroin' was developed from codeine, and methylamphetamine, (Pervitin) from cough medicine and nasal decongestants.

(dd) called 'crystal meth' or 'ice' in the UK, 'Pervitin' in the Czech Republic)see Annex A for further details of Pervitin usage in the Czech Republic

⁴⁵⁷ EMCDDA(2014)*ibid*. In 2011 there were seized 338 pervitin laboratories and in 2012:235

⁴⁵⁸ Deutsche Welle(2013) *Politicians aim to end spread of crystal meth*
www.dw.de/politicians-aim-to-end-spread-of-crystal.../a-166008549(15022013)

⁴⁵⁹ Prague Post (2014) *Bavarian-Czech cooperation leads to decrease in Germans on Pervitin*.
www.praguepost.com/.../41599-bavarian-czech-cooperation-leads-to-dec.(170914)..

⁴⁶⁰ Hart C L, Csete J, Habibi D (2014) from Columbia University *Methamphetamine Fact v Fiction*
www.opensocietyfoundations.org/.../methamphetamine-dangers-exaggerated..

⁴⁶¹ Czech Republic;(2009) *Drug Situation Annual Report 2009*
vlada.cz/assets/.../AR_Drug_Situation_Czech_Republic_2009

⁴⁶² The Czech Republic(2014) *Drug Situation. Annual Report 2014* *ibid*

Overall the Czech Republic has low drug taking rates compared with the rest of Europe and with the UK.

	Czech Republic	United Kingdom	European Countries	
			Min	Max
Opiate users/1,000	1.5	8.1	0.2	10.7
new clients %	18.2%	33.4	6	93
Cocaine users/1,000	0.4	2.0	0	2
Amphetamine/1,000 including Methamphetamine	67.4	0.7	0	67
Ecstasy /1,000	0.6	1.3	0	10
Cannabis/1,000	9.2	6.4	0	10
Problematic Drug Users/1000	5.71	9.19	1.8	10
HIV users injecting/million	0.6	1.8	0	53.7
New diagnoses				
Offences related to drugs	5,317	134,241		
related to possession/use	1,911	87,033		
Deaths/million	3.9	38.3		

Source *EMCDDA statistics 2014* (almost all the figures are from 2012)

Table 34 Czech Republic UK and Europe compared

High risk stimulant drug users for the 15-64 age range was 4.24 persons per 1,000 (mainly home-made Pervitin users). Opioid users were 1.47/1,000. Daily cannabis users were estimated to total 30/1,000.⁴⁶³

The Czech National Drug Policy could be said to have started in 1992 when the Non Governmental Organisations (NGOs), which were largely responsible for existing measures to help drug addicts, jointly wrote to the Government offering to coordinate their efforts with those of the State, the so-called Christmas Memorandum⁴⁶⁴. NGOs had already instigated needle exchange and opioid substitution therapy in 1987. In 1993 Czechoslovakia split into Slovakia (retaining the Russian orientation of prohibition with severe penalties for drug use) and the Czech Republic, which was West leaning, and in the same year formed its National Drug Commission (NDC) with the remit to reject criminal sanctions for drug use and to provide harm reduction services.

Today the NDC includes representatives from the ministries of the Interior, Finance, Education, Youth & Sport, Defence, Labour & Social Affairs; Justice and Health as well as the Commissioner for Human Rights and representatives of all the fourteen regions in the country and of the NGOs.

The Director of the NDC is a person who has worked directly with clients, thus maintaining the link with reality which a (non-involved) civil servant might not be able to achieve.⁴⁶⁵ The policy introduced is similar to the Swiss Four Pillars model: prevention, treatment and social integration, harm reduction and drug supply reduction (policing).

⁴⁶³ EMCDDA(2014) *ibid* p.2

* a note on Pervitin is given at Annex A(dd)

⁴⁶⁴ Csete J (2012) *ibid* p 16 et seq

⁴⁶⁵ Csete J (2012) *ibid* p 17

There are the supporting domains of coordination, funding, monitoring, research, evaluation and international cooperation. In 2010 the National Drug Strategy for 2010-2018 was approved with three yearly action plans and priority setting.

In 2012 the Czech Republic's Ministry of Education, Youth & Sport introduced Europe's first system of accreditation for instructors in the prevention of psychoactive drug use. An Inspection of Schools programme started in the same year, and Certification a year later.

The European Union Drug Abuse Prevention pilot project (EU-DAP) 'Un-Plugged' was run in the Czech Republic from 2006-10. Following a thorough evaluation it showed there had resulted a significant reduction in the use of tobacco, alcohol and drugs of abuse. Following this the programme was scaled up throughout the country. A further 100 teachers were trained and targeted at vulnerable children. A parents' module was also developed.⁴⁶⁶

A follow up survey was carried out in 2005-6⁴⁶⁷ and the report showed the programme to have been effective⁴⁶⁸

Needle exchange since 1987 has been a major feature of the harm prevention programme. In 2009 about 4.9 million needles were issued through 95 outlets (drop-in centres, street-based services, many run by NGOs, pharmacies, dispensing machines and GPs' practices). The Government estimated that there were about 37,000 people using drugs in the country⁴⁶⁹ In Prague alone the 11,400 drug injectors used 2.1million needles⁴⁷⁰.

This comprehensive needle coverage is considered to account for the very low HIV/AIDS prevalence among injecting drug users, given in 2010 Annual Report to be less than 1% (7 persons). Hepatitis B and C amongst injecting drug users is also very low., and contact with clinics by injecting drug users is very high at 70% .⁴⁷¹

The present day drug policy in the Czech Republic is probably unique in that it is based upon a scientific study of re-criminalisation of drug policy. This showed conclusively and paradoxically that *prohibition resulted in drug usage and its consequences getting worse, not better.*

Drug policy in the Czech Republic developed out of the post-communist era of overall personal freedom and freedom from drug legalisation. This was followed by a re-imposition of controls, but moves to reverse that soon began. However before that started a

⁴⁶⁶ EMCDDA (2014) *Situation summary for the Czech Republic*

[Emcdda.europa.eu/publication/country-overviews/cz](http://emcdda.europa.eu/publication/country-overviews/cz)

* see Annex A (ee) for a chart showing psychoactive drug use in the Czech Republic

⁴⁶⁷ EU-Dap Trial 2005-6 was a follow up trial of schools in Italy, Belgium, Austria, Sweden, Spain Greece and Germany. 150 schools and more than 7,000 children took part
www.eudap.net/Research_StudyDetail.aspx

⁴⁶⁸ EU-Dap (2012) *Final Technical Report Results of the evaluation of a school prevention programme*
www.eudap.net/pdf/finalreport2.pdf

Page 11, paragraph 5.3 summarises: '*the survey shows a clear protection for students; intervention groups smoked 30% less during the past 30 days, 14% less in a regular way and 30% less daily, when compared with the controls. Drunkenness in the past 30 days was reduced by 28%, and cannabis by 24%. The use of other drugs, though rare was reduced by 11%*'

I am grateful to Serena Vadrucchi of the OED, Piedmont, for having put me on the track of refs 479 and 480

⁴⁶⁹ Csete J (2012) *ibid* p27

⁴⁷⁰ Csete J (2012) *ibid* p 28

⁴⁷¹ Czech Republic (2010) *Drug Situation Annual Report 2009*
[Czech_Annual_Report_Drug_Situation_2009_EN_www.pdf](http://www.czech-republic.cz/Annual_Report_Drug_Situation_2009_EN_www.pdf)

scientific survey of the effects of criminalisation was carried out, and that reported conclusively that matters worsened as a result. That set the scene for future drug policies being evidence based. The current system is similar to the Swiss Four Pillar Policy.

A measure of decriminalisation of drug possession for personal use and of growing is allowed. All psychoactive drugs have a relatively small usage with the exception of cannabis and of Methylamphetamine which has a high uptake. However needle exchange was initiated early on and is widespread and the HIV and death rates amongst users is extremely low.

The drugs and health promotion programme in schools and for young people is very effective and has been used in several European countries.

Chapter 5. Five Countries Compared

In this chapter good practice from the five countries will be drawn together to provide an analysis and synthesis for possible use in the United Kingdom. Firstly a comparison is shown between the UK and the five countries studied: United Kingdom, Czech Republic, Germany, Netherlands, Portugal and Switzerland.

	UK	Czech Republic	Germany	Netherlands	Portugal	Switzerland
Problem opiate users /1000	8.1 c	1.5b	3.4c	0.9b	nk	0.12e
Cocaine /1000	2.0a	0.4b	0.8b	1.2e	2.0b	0.3b
Amphetamine /1000	0.7a	0.4b	0.7b	0.4e	0.0b	0.2b
Ecstasy /1000	1.3a	0.6b	0.4b	1.4e	0.3b	0.3b
Cannabis /1000	6.4a	9.2b	4.5b	7.0e	2.7b	2.9b
Problem drug users /1000	9.19c	5.71b	4.6c	nk	nk	nk
Injecting drug users /1000	3.3c	5.4b	nk	0.2e	nk	nk
HIV new cases per year /1,000,000	1.8b	0.6b	1.0b	0.4b	5.3b	nk
Drug related deaths	38.3b	3.9b	3.9b	10.2b	4.2c	1.70

Table 35 Comparative Drug Statistics

Source EMCDDA Statistics & Suchtmonitoring in der Schweiz
a 2013 b:2012 c:2011 d:2010 e:earlier

An effective drugs policy must be based on the evidence. The UK's drug laws are failing and there is evidence enough in the experiences of the five countries studied to formulate an effective policy now. In the past drug policy was based upon ideology and political whim*, but sentiment is now changing and a recent MORI poll reported that 70% in the UK believe the Drug Laws should be changed⁴⁷². The debates in Parliament on 17th October 2013⁴⁷³ and 30th October 2014⁴⁷⁴ also showed that the majority of parliamentarians present were in favour of changes to the current Drug Policy. (Action however is unlikely in the near future on account of the forthcoming election in 2015)

This analysis will be based on the Swiss 'Four Pillars Policy,' the first part of which is promoting the prevention of exposure to psychoactive drugs amongst children and young adults, and prevention of the move from casual drug use to addiction, and from less dangerous to more harmful drugs.

* see the insistence by the Prime Minister Gordon Brown on reclassifying cannabis as a Class B drug (Chapter 1) and the introduction of khat to the Scheduled Drugs list (Chapter 1)

⁴⁷² Sun Newspaper leading article (2014) *It is high time for a change* (Sun Newspaper 30th October 2014)

⁴⁷³ House of Lords (2013) *Hansard Debates for 17th October 2013*

<http://www.publications.parliament.uk/pa/1d201314/1dhansard/text/131017-00001.htm>

⁴⁷⁴ House of Commons (2014) *Hansard Debates for 30 October 2014* (pts 0002&0003)

<http://www.publications.parliament.uk/pa/cm201415/cmhansard141030-002&3.htm>

5.1 Prevention and limitation of risk

Health promotion is carried out in schools and youth groups in all the countries studied. Vulnerable children, those with drug-using parents, or from broken families are targeted especially. The Czech ‘Unplugged’ programme was evaluated and found to have a measurable effect in the short term. However studies on its long term benefits there have not been identified*, but on the follow up programmes in several European countries (EU-DAP 2005-6) the conclusion made is that

*“... results indicate a positive shift to prevent the use of alcohol, tobacco and other drugs among European students aged 12-14 years”.*⁴⁷⁵

Interactive internet activities as used in Germany, may be helpful for young adults. Fashions change too amongst drug users, as seen in Switzerland, and young people like to take risks with drugs as with other activities.⁴⁷⁶

An effective health promotion policy for drugs would be to deter young people if possible but to provide a safety net to provide for their fallibility of risk taking. The tactic used in Holland of making it possible to legally smoke cannabis in the coffee shops, thus diverting people away from hard and illegal drugs on the streets, was successful. Cannabis use in Holland is high, whilst the use of hard drugs is low; in the UK by contrast the cannabis uptake is slightly less than in Holland but here the usage rate of hard drugs is much higher, and the UK drug-related death rate is almost four times that of the Dutch. A degree of decriminalisation of cannabis introduced in Holland appears to be working there.

Germany has introduced coffee-shops. Portugal, Switzerland and Spain are discussing it. Although cannabis is tolerated in the coffee-shops by the authorities, quantity and quality⁴⁷⁷ is strictly regulated, ‘cutting’ with tobacco and hard drugs completely banned. A coffee shop may not hold more than 500 grammes of cannabis at any one time, and so there is a constant ‘back door’ resupply usually from small scale growers⁴⁷⁸, to which degree of legalisation, the attitude of the police is of *gedoogenheid* (tolerance).

Similar decriminalisation is taking place with the risk-reduction activities of ecstasy assay at raves in several European countries and in the UK⁴⁷⁹. In remarking on the death from ecstasy poisoning of ‘Martha’ in the House of Commons debate Caroline Lucas MP commented:

* letter dated 19 December 2014 to Dept of Addictology Charles University Ovocny trh 3-5, 116 36 Praha 1, Czech Republic

3 House of Commons (2014) *Hansard Debates for 30 October 2014* (pts 0002&0003)

<http://www.publications.parliament.uk/pa/cm201415/cmhansard141030-002&3.htm>

⁴⁷⁵ European Union Drug and Alcohol Project (2009) *Research Area: Study Details - EU-Dap* . www.eudap.net/Research_StudyDetails.aspx

⁴⁷⁶ *It has to be born in mind that if the risk is reduced so might be the allure of using a particular forbidden substance. In Switzerland the medicalisation of heroin is said to be the reason for people losing interest in it. In the UK changing the grading of cannabis from B to C was followed by a decrease in cannabis uptake. Cause and effect is not proven but such matters are important when planning health promotion. We found in Gt Yarmouth that the reaction of some schoolchildren to the drug awareness film was to excite their interest rather than putting them off. It is believed that boredom with cannabis and police pressure to prevent its use has caused some people to turn to the use of ‘legal highs’.*

⁴⁷⁷ *Jellinek Drug Testing Service (in Holland)*

<http://www.jellinek.nl/informatie-over-alcohol-drugs/drugs-test-service/> ... ‘Jellinek Drug Testen’ provides an over-the-counter drug testing service, together with up to date bulletins about dangerous drugs which have entered circulation.

⁴⁷⁸ Haskell M (2012) *Going soft on drugs* (National Post 12 April

2012) fullcomment.nationalpost.com/.../mark-haskell-smith-going-soft-on-drugs.

⁴⁷⁹ Pidd H (2014) *Manchester Warehouse Project Club introduces drug testing*. The article describes how Professor Fiona Meecham provides a voluntary Ecstasy testing facility at the entrance to the Club. (Guardian Newspaper 1st December 2013). *It is salutary to reflect that if ‘Martha’, who died after taking a tablet of excessively potent Ecstasy, had gone to the rave monitored by Professor Meecham, she would still be alive today.*

“...under prohibition it is impossible fully to educate people such as Martha, because there is no way to tell what the drugs contain. Prohibition has not stopped risk-taking, but it has made those risks much more dangerous. We need a regulatory model that reduces the risk if drugs do get into the hands of young people”⁴⁸⁰
It would be to reduce the risk of the drug at its source by quality control⁴⁸¹.

5.2 Treatment

The aims of treatment are to help addicts break the habit, improve their mental and physical health and to encourage social re-integration. As explained in Chapter 1, the majority of people who use psychoactive drugs for recreational reasons do not become addicted. However those who do, have become chronically ill, needing the appropriate medical care. The illness is multifaceted, with psychological, medical, social, ethnic and economic problems needing to be addressed, both on an individual and public health level⁴⁸². Such action might not be sustainable if a country is unable to afford the full supporting care⁴⁸³, because of economic strains. The immediate object of treatment is to provide substitution therapy, and conventional therapy for intercurrent medical conditions. It is also necessary to provide for the supporting areas of care listed above. Once a patient is securely on substitution therapy, and is dependent upon the physician for his drug needs, and hopefully emotional needs as well, abstinence therapy can start. The Swiss Heroin Assisted Therapy trial is in reality the legal use, prescribed free, of an illegal substance, which resulted in a significant decrease of criminal behaviour as well as improvements in health. Five other countries have followed Switzerland's lead.

	UK	Czech Rep	Germany	Netherlands	Portugal	Switzerland
Injecting drugs users/1000	3.0	5.35	nk	0.22	2.0	nk
IDUs & PDUs						
% in treatment	44.5%	90.6%	c.100%	c.100%	nk	nk
Deaths/million	38.3	3.9	3.9	10.2	4.2	3.1

Table 36 Outcome of Treatment of Injecting Drug Users

Source ECMDDA Statistics and Suchtmonitoring in der Schweiz.

The ‘process effectiveness’ of the substitution therapy may be measured by the percentage of intravenous drug users on therapy. The ‘outcome effectiveness’ may be measured by the death rate.

⁴⁸⁰ Lucas C House of Commons(2014)ibid p18/37Column437

⁴⁸¹ See footnote 2 on page 1 Chapter 4, in which the onetime UK Ambassador to Afghanistan recommended that the opium crop there should be bought up for the drug market of the western countries and made available through a regulated market. See also footnote 1 on that page; if Jamaica is readying itself for a lucrative export market of cannabis to those States in the USA which have legalised it, It is a reasonable assumption that they would check it for quality before using it.

⁴⁸² Lucas C House of Commons(2014)ibid p 17/37Column 436 &435

⁴⁸³ Murkin G (2014)Drug decriminalisation in Portugal: setting the record straight
www.tdpf.org.uk/.../drug-decriminalisation-portugal-setting-record-strai.

5.4 Harm Reduction

A drug user who has become dependent may be harmed physically or mentally. Then there is the harm which may result from the use of drugs of poor quality or unknown concentration. Next there is the harm caused to a user who is imprisoned, gains a criminal record, is stigmatised and who may, as a result, sustain damage emotionally, socially, to his family and career.

Finally there is the harm to society through the expenditure of large sums of money on legal processes which have been spent to little or no benefit to the population as a whole.

To reduce the harm to the user from the drug itself: the greater the number of dependent, problematic and injecting drug users, receiving treatment and the medical support services needed, the better will be the population based outcome. The point has been made above, that even if a person is being maintained on substitution therapy, and may be making progress towards a successful abstinence outcome, they will need support as well. Drug Consumption Rooms and similar facilities have been mentioned before. In the Czech Republic success in this area is due to the '*dense network of low threshold programmes*';⁴⁸⁴ all countries surveyed provide them. Needle +/- syringe exchange is also provided in all five countries, with the most comprehensive provision being in the Czech Republic; in 2009 there were 37,400 problem drug users, and 4.9 million needles were dispensed⁴⁸⁵, the outcome being a very low annual rate of new HIV patients⁴⁸⁶

A comparison of the HIV rate amongst injecting drug users is shown:

	UK	Czech Rep	Germany	Netherlands	Portugal	Switzerland
% population who are injecting users	0.39	0.4	0.17	0.03	0.47	0.65
% IDUs HIV positive	2.3	0.05	2.9	9.0	5.6	1.4

⁴⁸⁴ Annual Report (2008) *The Czech Republic Drug Situation* page 2

http://www.drogy-info.cz/index.php/layout/set/english/annual_reports_and_other_main_resources

⁴⁸⁵ Csete J (2014) *A Balancing Act:: Policymaking on Illicit Drugs in the Czech Republic* (Open Society Foundation) page 26 (one third were heroin users, two thirds Pervitin users)

⁴⁸⁶ Csete J (2014) *ibid* page 43 where she states: '*...to the degree that control of HIV is an indication of drug policy effectiveness, the Czech experience merits very high marks*'.

⁴⁸⁷ Mathers B M et al (2008) *Global epidemiology of injecting drug use and HIV among people who inject drugs; a systematic review by the Reference Group to the UN on HIV and Injecting Drug Users*. www.who.int/hiv/topics/idu/LancetArticleIDUHIV.pdf

Mathers et al point out '*...that Australia and New Zealand have maintained very low levels of HIV infection, despite a high level of injecting drugs. This is attributed to the swift introduction of needle and syringe programmes when the HIV infection was first noted in the 1998's*'

Table 37 percentage of population who are Injecting Drug Users and percentage of IDUs who are HIVpositive

Source: Mathers et al⁴⁸⁷

If users are to be protected against drugs which are contaminated, impure or of unknown quality, they should be controlled at the production stage and ‘spot tested’ at the place of issue. However psychoactive drugs used for recreational purposes are illegal, and drugs gangs would not allow their means of production to be assessed and quality controlled. It is only possible if the production of drugs is in the hands of a legal organisation. In the case of the Czech Republic, where it is permitted to grow a few plants to provide for personal consumption, there exists the inspection possibility of cannabis content in the plants under cultivation. Otherwise the only quality checks available (unofficially) are those mentioned above at raves and dance halls.

This was mentioned at the House of Commons debate on 30th October 2014 by Lilley, who remarked that the

*“...worst option is in falling between two stools; decriminalising their use (in the coffee shops) whilst leaving the supply in the hands of gangs”*⁴⁸⁸

and went on to say that a distinction should be made between hard and soft drugs (as several of the countries studied already do) and that cannabis should be legalised. There should be legal outlets for buying cannabis under strict control.

Riffkind put the problem clearly with the recent criminalisation in the UK of Khat *‘Criminalise drugs and it’s criminals who sell them...legalise them and the criminals are out of the loop. So, you can then tax, and regulate, and generally start treating what has formerly been a police problem as the public health problem it clearly is’*⁴⁸⁹

The Swiss government succinctly put the dilemma in its submission to the UN for the forthcoming UNGASS as follows:

‘...if (the State) accepts the reality that people use drugs, it must also arrange for the appropriate monitoring of these products; ensuing safety with ongoing illegality of these substances is impossible’ (see Chapter 4)

Reference is also made to footnote on page 1, chapter 4 where the ex-British Ambassador to Afghanistan recommends that the *whole opium crop be bought up and entered legally into the UK heroin market.*

Finally the individual user may be harmed through the processes of the criminal law, as it is applied in the UK. As mentioned above 55% of prison inmates here are in for drug related offences: acquisitive crimes to pay for their addiction, for trafficking or supply or merely for possession. 1,000 people are imprisoned annually for possession alone⁴⁹⁰. Furthermore a criminal record blights a person’s family and social life and their career*.

On mainland Europe, in the countries studied, all pure drug offences (that is excluding acquisitive crimes to fund a drug habit) are dealt with under the civil code or administratively and it is legal to possess a small amount of drugs for personal use. Thus Portugal lists quantities permitted** ; if exceeded the offender is brought before a ‘dissuasion commission panel’, where treatment, care and rehabilitation are encouraged. The Netherlands recognises drugs in two groups: hard and soft and tolerates the latter but not the former. In Germany so long that the quantity of the drug is of a small amount, prosecution is . In Switzerland only two drugs are used frequently: heroin dealt with

⁴⁸⁸ Lilley P (2014) House of Commons ibid page 25&26/37

⁴⁸⁹ Riffkind H (2014) *The Spectator* 28 June 2014 p30

⁴⁹⁰ Huppert J (2014) House of Commons ibid p 30/37 Column 451

* see Annex A Endnotes at (q) *Stuart’s Story*

** see Annex A Endnotes at (v) *quantities permitted for possession in Portugal*

vigorously by the medical services and cannabis, where if more than 10g are in possession evokes an on-the-spot fine. The Czech Republic has a tariff of permitted possession and another of permitted number of plants.

The last item to be considered in harm reduction is the *harm to the state itself*. This is the cost of policing prohibition which is estimated to be between £3billion⁴⁹¹, £13.9billion⁴⁹², even up to £16billion⁴⁹³, money which might be better spent. In this project it is not appropriate to analyse the costings, yet a few indicators point the way

(a) Portugal's prison population has halved since the reforms were stated there in 2001

(b) in Holland 8 prisons closed in 2009

(c) The Czech Republic's audit of two years criminalisation policy estimated the cost of two years of drugs' prohibition to be about CZK37million.(cc)

(d) The US State of Georgia reduced its drug-related prison population from 24,000 to 10,000⁴⁹⁴

Thus harm to the State would be reduced if it moves away from the prohibition ideology.

Secondly there is the harm caused to the citizens of the state who have to endure the crimes caused by drug addicts seeking funds to pay for the habit⁴⁹⁵. Finally there is the harm caused by the drug cartels, rackets and gangs locally and internationally.⁴⁹⁶ If drugs were legalised both these harms would not exist or be substantially reduced. The harmful effects of drug laws have been explored in detail in Chapter 3.

The last part of the Four Pillar Drug Policy is Policing. The recommendations here are naturally based upon the requirement for enforcing drug policy laws as they are now. My proposed ideal Drug Policy would reduce the need for police as discussed in Chapter 6.

(cc)The Impact Analysis Project of New Drugs Legislation in the Czech Republic

⁴⁹¹Blunt C (2014) House of Commons ibid p 36/37 Column 457

⁴⁹²Blunt C (2014) House of Commons ibid p 36/37 Column 457

⁴⁹³Transform(2009)*The cost of drug laws: £16 billion* . Home Affairs Politics 7 April 2009
www.politics.co.uk > News > Home Affairs

⁴⁹⁴Phillips S (2014)House of Commons ibid p5/36 Column 463

⁴⁹⁵Jacobs P (2014) personal communication see Annex A (d)

⁴⁹⁶Lucas C (2014) House of Commons ibid p 18/37 Column 436

Chapter 6. Conclusion: The Ideal Model Drug Policy

The Aim of a Drug Policy should be to deter people, especially young people, from starting using them, but if they do, reduce the risk and provide a safety net of care, so the harm they might cause themselves and others would be minimised.

The purpose of the policy is not punishment, which has been shown to be ineffective. It is to maintain the health of the population and so it has to be driven by Public Health at all levels.

Drugs should be legalised and largely decriminalised.

Legalisation. The government or its agencies procures supplies of all psychoactive drugs, which are subjected to quality control. Distribution is through government controlled and licensed outlets. Here they will be sold in limited amounts to users at a price taxed, but well below the street price. Psychoactive drugs will be graded A for those which might cause unacceptable harm, and B for those which do not cause such harm.

Decriminalisation Users are entitled to a list of substances similar to the one in Portugal/Czech Republic, and the possessor of a quantity on the list is not subject to arrest. If a user possesses more than the permitted quantity they will be subject to the civil law, and subject to interview by a Commission for the Dissuasion of Drug Addiction, which would function as it does in Portugal.

Users would be permitted to grow their own plant based psychoactives in stipulated quantities. More than that would be deemed illegal and subject to police destruction.

The 'Four Pillar Policy' as used in Switzerland and elsewhere would form the basis of the proposed future Policy.

Prevention.

To promote the avoidance of drug use especially amongst children and youth, school based instruction will be given involving parents. Special emphasis will be given to vulnerable children, those with drug using parents, those who have suffered abuse. The EU-DAP scheme is appropriate. Teachers will be competence certified, and outcome measurements will be routine. On-line facilities will continue (FRANK in the UK and others). For young people of an older age instruction will continue at University and in Clubs.

To prevent young people moving from casual use to harmful use and from less harmful drugs to more harmful drugs: coffee-shops in the Dutch and German style will be allowed under regulated conditions and rules for young people older than 18 years.

Treatment aims to help addicts break the habit, improve their health and reintegrate into society. All dependent drug users who can be, should be on substitution therapy and provided with as full a range of social, economic, psychological, housing and employment support as can be afforded by the State. Intercurrent infections should be treated. General practitioner should provide the service.

Harm Reduction

Needle and syringe supply should be very widespread; Drug Consumer Rooms should be situated in every moderately sized town, providing injection facilities and social support.

People at the point of need protection from harm. Municipal authority should only be granted for raves, pop concerts etc unless there is first aid, a rest and re-hydration room and a drug purity testing facility on site.

Enforcement

Once the State has taken over the acquisition and supply of psychoactive drugs and undercuts street prices, (yet taxed as are tobacco and alcohol) traffickers and racketeers will go out of business. New Psychoactive Drugs might still be imported and should be dealt with vigorously.

Once drugs are decriminalised the police function in respect of persons possessing drugs will cease. Carrying drugs for others might occur, but not frequently.

In Holland and Portugal where this is already the case the imprisonment rate has fallen steeply, and it would be appropriate to release prisoners incarcerated for those reasons. The costs of policing, the judiciary and the prisons will plummet and the money used should provide for the harm reduction advised, and also produce a surplus for use elsewhere

Administration of the drug care system has been less successful with politicians and civil servants running the system, on account of political or ideological bias. As has been shown in the Czech Republic policy management is most effective if it is in the hands of people who have worked at the interface with patients and drug addicts.

ANNEX A

Explanatory Endnotes Index

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ANNEX A Explanatory Endnotes

Chapter 1 History and Background

(a) *Drugs, Crime and Public Health*

(i) Drugs and Crime the 'Tripartite Framework', why drug users take to crime.

- a. Psychopharmacological: some drugs active on the brain increase aggression and decrease inhibition.
- b. Economic and compulsive: drug users need to raise the funds to pay for the habit
- c. Systemic: the drug market is criminal and violent and drug users may have to act thus to achieve their objectives.

There is an increased risk if the offender is ethnically Afro-Caribbean, male, unemployed
(Stevens page 36)

(ii) Social influences and drug taking

- a. Status: drug use fills a need for status in the community
- b. Coping: drugs relieve feelings of insecurity and the pain of life.
- c. Structure: provided to those deprived people whose lives lack purpose and meaning
- d. Saturation: because everyone else is doing it.

Drug taking may be a retreating adaption to failure to live out the dream of life or an active search for status, meaning and excitement. (Stevens page 41)

Stevens A (2011) *Drugs, Crime and Public Health* Routledge

(b) *The Good Friday Experiment*

This account is rendered almost verbatim, for it is not only such an interesting event, but it points out the unpredictability and long term effects of drug use, in this case a hallucinogenic drug, psilocybin. (magic mushrooms)

On Good Friday 1962, (Walter) Pahnke administered capsules to twenty Protestant divinity students, who then attended a religious service. Half of the capsules contained psilocybin, an extract of hallucinogenic mushrooms; the other half contained a placebo. Six months after the experiment, the subjects who had taken the hallucinogen, to a far greater extent than the control subjects, reported having had a mystical experience that produced persisting positive changes in attitude and behaviour. Moreover a follow-up set of interviews, conducted twenty-four to twenty-seven years after the original experiment, found that these effects persisted. The experimental subjects, most of had been member of the clergy all their lives, and so should be as qualified as anyone to know a religious experience when they have one, 'unanimously described their Good Friday psilocybin experience as having had elements of a genuinely mystical nature and characterized it as one of the high points of their spiritual life' Most of the control subjects, on the other hand 'could barely remember even few details of the service'

My feeling on this is that if a person is exposed to a religious experience whilst taking such long acting psychoactive drugs, well, that is not too harmful. However what if a person taking a drug is watching a TV programmes showing violence, say rape or murder, is that then being embedded in their mind, to remain as a latent threat perhaps for many future decades?

from Koppleman A (2006) Drug Policy and the Liberal Self. 100 NWUL Rev279, (2006) p.288 footnote 44

(c) *Rifkind's Views on Khat*

In *The Spectator* (2014), Hugo Rifkind states that Khat has been banned as a Category C drug, because Britain's Somali women don't want it. They complained that their men folk spent so much time fuddled by it they couldn't work. But why ban it, Rifkind asks, for most countries are doing exactly the opposite with similar substances such as marijuana.

'Criminalise drugs and it's criminals who sell them...legalize them and the criminals are out of the loop. So, you can then tax, and regulate, and generally start treating what has formerly been a police problem as the public health problem it clearly is'

Rifkind H (2014) *The Spectator* 28 June 2014 p30

(d) The nature of thieving by drug addicts.

Peter Jacobs, a retired County Court Judge, of many years experience (see acknowledgments) told me how the thieving is done. The aim is to get about £50-£100 together to pay for the next 'fix' at about lunchtime. Thieves work in pairs; the one on lookout and to do the carrying of the loot, whilst the other enters the shops to do the pilfering. Very little is stolen in any one shop so that if the villain is caught, the shopkeeper usually lets them go, feeling it is not worth the trouble and time to call the police and initiate a prosecution. If the thief gets away with it, he hands the goods to their mate outside, so that he, the thief, is not caught in a shop with a lot of stuff on them which cannot be accounted for. And so the morning round continues until the required amount, usually £300 worth of articles, has been stolen, which is then taken to a prearranged pub frequented by the fence who pays the addict £50-£100 and will dispose of the goods in a nearby market.

(e) *The Opium Wars*

In the early 1800's the Dutch exported Indian opium to China and introduced opium pipe smoking there. This trade was overtaken by the British East India Company exporting vast quantities from Bengal and Bihar to China, which the Emperor banned in 1799. Despite that the trade continued with Jardine, Matheson of London taking the main role, until China again banned it in 1839. British warships and an expeditionary force sent in retaliation precipitated the First Opium War against China, which defeated in 1841, agreed to the import of limitless opium and to ceding Hong Kong to Britain as its main trading port. Further attempts by China to limit the opium trade resulted in the Second Opium War with Britain and France, and defeat again for China. British parliamentarians were by no means all in accordance with the 2nd Opium War and many challenged the legitimacy of it and of the colonialisation which it implied together with the export of what was now realised to be a dangerous drug. The use of opium started to decline thereafter although there was enough in circulation to cause to start the moves to ban it entirely.

(f) *Kubla Khan, A vision in a dream*

Samuel Taylor Coleridge

(for an example only the beginning and ending of the poem is given)

In Xanadu did Kubla Khan
A stately pleasure-dome decree:
Where Alph, the sacred river, ran
Through caverns measureless to man
Down to a sunless sea.
So twice five miles of fertile ground
With walls and towers were girdled round;
And there were gardens bright with sinuous rills,
Where blossomed many an incense-bearing tree;
And here were forests ancient as the hills,
Enfolding sunny spots of greenery.

.....

And all who heard should see them there,
And all should cry, Beware! Beware!

His flashing eyes, his floating hair!
Weave a circle round him thrice,
And close your eyes with holy dread
For he on honey-dew hath fed,

(g) *Excerpt from Ginsberg's poem Howl*

*I saw the best minds of my generation destroyed by madness, starving, hysterical naked,
dragging themselves through the negro streets at dawn looking for an angry fix,
angel headed hipsters burning for the ancient heavenly connection to the starry dynamo in
the machinery of night,
who poverty and tatters and hollow-eyed and high sat up smoking in the supernatural
darkness of cold-water flats floating across the tops of.....*

(h) *Atkinson's and Barker's 'Royal Infants' Preservative'*



The heading at the top of the label reads :

The only Infants' Patent Medicine under the Royal Patronage

Source The Quack Doctor Atkinson and Barker's Royal Infants' Preservative

(i) *Opium Dens in 19th Century London*
from the 'the Man with the Twisted Lip'

‘...the old man at my side ,..he sat now as absorbed as ever, very thin, very wrinkled, bent with age, an opium pipe dangling down from beneath his knees, as though it had dropped in sheer lassitude..... in doddering loose lipped senility.

“ Holmes!” I whispered “what on earth are you doing in this den?”

Dr Watson had ventured into the lower regions of Limehouse to seek his old friend Isa Whitney, who had become a slave to opium, and now with a yellow pasty face, drooping lids and pin-point pupils, had become the wreck and ruin of a noble man. Then to his astonishment he comes upon Sherlock Holmes in deep disguise on the track of 'The man with the twisted lip' and so begins another of the great detective's famous adventures.

Chapter 2 Morality

(j)*Methodological Issues on Opinion Polls*

Public opinion is shaped by a large number of different factors and this make its measurement difficult and imprecise. The statistics which are derived from opinion polls are similarly accurate only up to a point. They are useful though, for as the saying goes: ‘*statistics are pointers to the truth*’. However it is important to try to find out what the public thinks, and public opinion polls aim to do that. It is useful to remember the problems which have to be taken into account when interpreting them. These are

Sampling error: this is error in measurement. The smaller the population sampled, the larger is the potential error; thus for a sample population of 1,000 the error is 3%, in other words $\pm 3\%$ of the result is the nearest accuracy which may be achieved.

Non response bias: if people are asked to complete a questionnaire they well not do so, because they may not wish to admit to doing things implied. So a questionnaire submitted to people who may or may not use drugs, may get a greater response from those who don't use drugs, than from those who do, for the latter won't want to admit to doing so.

Response bias: people who respond to a questionnaire may not be truthful in their answers.

Ambiguous questions: lack of clarity may result in answers which have little value, and negative questions may confuse the issue.

Coverage error. The sampling may not be representative of the overall population. Thus in London, where there is extreme ethnic diversity in different areas, the survey will produce erroneous outcomes unless that is taken into account.

Sources

Transform : *public opinion on drugs* File://C:/Users/1/Appdata/Local/Temp/Low/DFRCRSUB.htm

Wikipedia: *opinion polls* <http://en.wikipedia.org/wiki/Opinion.poll>

(k) *The House of Commons Debate on 30th October 2014*



Source Palmer E (2014) *Only 21 out of 650 MPs Attend Parliamentary Debate on UK Drug Laws*
International Business Times 31st October 2014 www.ibtimes.co.uk/only-21-out-of-650-MPs-attend-parliamentary-debate

The article was scathing about the apparent lack of interest of MPs, for only 3% of their total attended the debate. However as Rupert Huppert MP remarked a poll taken of MPs shortly before the debate revealed that 77% were in favour of some legalisation and decriminalisation “.. as long as my name is not published”. The ideology of being ‘soft’ or ‘tough’ on drugs still pervades especially perhaps with an election looming not six months ahead. Mr Huppert it might be noted lost his seat at the election.

(1)Relativism & reflexivity.

Descriptive moral relativism, implies that people recognise that there are different concepts of morality in different circumstances. No judgement is made on whether the local morality is right or wrong from the perspective of one’s own position. An example might be of an anthropologist describing the customs of the tribe being observed.⁴⁹⁷ A person observing a drug taking scene may describe it, but does not make comment on its morality.

Meta-ethical moral relativism maintains that cross-cultural judgement of morality is invalid. This concept starts with Descriptive Relativism, but goes on to maintain that if a judgement of the morality of an issue *is* to be made, that can *only* be done from the perspective of the local participants. An example might be polyandry amongst Tibetans; whether a European missionary feels that to be immoral or not may be important to him; the meta-ethicist would say that only a Tibetan is in a position to have a valid opinion. Only a drug user is entitled to judge whether what they are doing is moral or not; it is not for the patient’s doctor to do so.

Normative moral relativism implies that there are no universal moral standards. This means that we ought not to judge but to tolerate and accept the moral behaviour of others even though this may be counter to one’s own concept of morality. This might well lead to

an attitude of ‘anything goes’. Kreeft¹ suggests that if a person has a moral conviction of the rightness of doing something, then they have the right (*in their mind*) to believe that and act on it, even if *you* know it to be morally wrong. Thus he refutes the validity of moral relativism. So a normative moral realist would accept that as the ritual murder of children in Africa, might be acceptable there, so it should be here.² The converse is perhaps easier to accept, in that intolerance should be shown towards normative moral relativism and traditions causing suffering and hardship elsewhere if practised in this country where they would not be acceptable. In the drug taking situation this concept implies the sense of acceptance of the user’s point of view on the matter; thus if the user says they are alright, and the doctor sees that obviously not to be the case, so under the tenets of normative moral relativism might feel it appropriate not to do anything further.

¹ Kreeft P (1999) *A Refutation of Moral Relativism*

www.peterkreeft.com/audio/05_relativism/relativism_transcription.htm

² Hall J (2013) *Torso of African boy detectives believe was killed in a ritual* .Independent Newspaper 7 February 2013 (the torso of headless boy found in the Thames in London on 21 September 2001 identified as being from the Yoruba tribe of Nigeria, and concerned in a tribal ritualistic killing).

Reflexivity

This refers to a situation of unintended or unconscious ‘feed back’ between a subject and the observer. An example might be the following: two anthropologists are studying the language of a remote tribe on a South Pacific island. The tribespeople listening to the two scientists talking to each other, start to pick up some English expressions and begin to incorporate them into their own language. Another example: the hospital chaplain had to counsel many young patients seriously ill with cancer, and started himself becoming depressed and developing what he thought were worrying symptoms.(I had to counsel the chaplain.)

(m) *Culture and Morality*

Barbara Copeland’s Story

Barbara Copeland was a medical missionary in Kenya sponsored by the (British) Order of St John and in 1960, when we met her there, she told me the following story. The Christian missionaries who came to the Lake Victoria Region in the early 1920’s found the people there, both men and women wore no clothing at all. That was appropriate to the extreme humidity and heat of the area. However the missionaries considered such nudity to be immoral and converted them not only to Christianity but to the wearing of clothes as well.

There were however no facilities for clothes washing unless they lived right on the lake, and so the result, as the medical missionary who told me the story explained, her main occupation was treating people with fungal infections of the skin or arthropod infestations. Both condition having been totally avoided before the missionaries started upsetting the local culture.

Another unrelated incident, which is worth relating, occurred before the missionaries got the locals to accept the need for clothing. When the railway line from Mombasa, on the coast of Kenya, to Kisumu on Lake Victoria, the furthest extent of the country, was opened, King George Vth and Queen Mary came to carry out the opening ceremony. The need to avoid their embarrassment, at being greeted by the crowds of naked Africans who would be sure to come to the event ,was anticipated by the colonial officials and thousands of loin cloths were distributed. Their Majesties were apparently astonished to find that the vast numbers of locals who had come to see them were all sporting white turbans.

(n) *Kant’s Views*

Kant's view is similar to the social contract theory of Hobbes in a few important respects. The social contract is not a historical document and does not involve a historical act. In fact it can be dangerous to the stability of the state to even search history for such empirical justification of state power (6:318). The current state must be understood, regardless of its origin, to embody the social contract. The social contract is a rational justification for state power, not a result of actual deal-making among individuals or between them and a government. Another link to Hobbes is that the social contract is not voluntary. Individuals may be forced into the civil condition against their consent (6:256). Social contract is not based on any actual consent such as a voluntary choice to form a civil society along with others. Since the social contract reflects reason, each human being as a rational being already contains the basis for rational agreement to the state. Are individuals then coerced to recognize their subjection to state power against their will? Since Kant defines "will" as "practical reason itself" (*Groundwork*, 4:412), the answer for him is "no." If one defines "will" as arbitrary choice, then the answer is "yes." This is the same dichotomy that arises with regard to Kant's theory of punishment (section 7). A substantial difference between Kant and Hobbes is that Hobbes bases his argument on the individual benefit for each party to the contract, whereas Kant bases his argument on Right itself, understood as freedom for all persons in general, not just for the individual benefit that the parties to the contract obtain in their own particular freedom. To this extent Kant is influenced more by Rousseau's idea of the General

n such a way that these maxims (subjective rules of behaviour) of you

Kant's categorical imperative .

The 'given' translations tend to more scholarly than illuminating and obscure, I believe, what is actually meant. Here I put forward my own renditions, in italics, of the original German text.

"Handle so, dass die Maxime (= subjektive Verhaltensregel) deines Willens jederzeit zugleich als Prinzip einer allgemeinen Gesetzgebung gelten könnte."

Behave in such a way that these maxims (subjective rules of behaviour) of your intentions could, at all times and places, serve as the principle of a general law.

"Handle so, dass du die Menschheit sowohl in deiner Person als in der Person eines jeden andern jederzeit zugleich als Zweck, niemals bloß als Mittel brauchst."

Behave in such a way that the humanity of yourself as well as other people is always used as an end in itself and never as a means to an end.

The text goes on :

Freiheit - für Kant der Grundbegriff der Moral - heißt nicht Schrankenlosigkeit, sondern Gehorsam gegen das selbst gegebene Sittengesetz, das jeder in seinem eigenen Gewissen erkennt.

Freedom, for Kant the fundamental concept of morality, means not the absence of restrictions, rather obedience to one's own concept of lawfulness, which everyone recognises in their own conscience.

Der Kategorische Imperativ

www.3sat.de/delta/62470/index.html accessed 11062014

(o)Paternalism

Is an essential aspect of Public Health Medicine; by infringing people's freedom of choice the Public Health Physician seeks to improve the health of the public, thus interfering with their autonomy and liberty in the promotion of good. There are several forms of paternalism: soft paternalism, hard paternalism, liberal and legal paternalism

1. Soft paternalism; to alter a person's inclination. For example encouraging teenagers not to drink, smoke or to take drugs, avoid junk food, take exercise and so on.

2. Hard paternalism: to go against something a person intends to do. For example preventing a person from jumping of a bridge and committing suicide.
3. Liberal paternalism: to manipulate choice with the intention of doing good. For example at a school lunch, putting the salads first on the counter and the chips last. In the supermarket persuade the management not to put the cigarette packets at the checkout.
4. Legal paternalism: persuade the authorities to get seat belts installed in cars, the fluoridisation of water to prevent tooth decay, forbidding smoking in public places to avoid 'secondary smoking' by children, making obligatory the wearing of crash helmets for motorcyclists.

Antipaternalism is the attitude that the Physician has no right to undermine a person's autonomy and understanding of what *they* consider best for themselves. In advising an individual on what, in the GP's opinion, is best for them, a GP has to stick to 'Non-Directive Counselling' so that their patient can decide for themselves which course of treatment they would prefer to undergo.

(p) *The Hippocratic Oath*

I swear by Apollo the physician and Asclepius and Hygieia and Panacea and all the gods and

goddesses as my witness, that according to my ability and judgment I will keep this Oath and this contract.

To hold him dear who taught me this art and equally dear to me as my parents, to be a partner in life with him and to fulfil his needs when required and to look upon his offspring as equals to my own siblings and to teach them this art, if they should wish to learn it, without fee or contract: and that by the set rules, lectures, and every other mode one of instruction, I will impart a knowledge of the art to my own sons, and those of my teachers, and to students bound by this contract and having sworn this Oath to the law of medicine, but to no others.

I will use those dietary regimens which will benefit my patients according to my greatest ability and judgement, and will do no harm or injustice to them.

I will not give a lethal drug to anyone if I am not asked, nor will I advise such a plan: and similarly will not give woman a pessary to cause an abortion

In purity and according to divine law will I carry out my life and my art.

I will not use the knife, even upon those suffering from stones, but I will leave this to those who are trained into this craft.

Into whatever homes I go, I will enter them for the benefit of the sick, avoiding any voluntary act of impropriety or corruption, including the seduction of women or men, whether they are free men or slaves.

Whatever I see or hear in the lives of my patients, whether in connection with my professional practice or not, which ought not to be spoken of outside, I will keep secret, as considering all such things to be private.

So long as I maintain this Oath faithfully and without corruption, may it be granted to me to partake of life fully and the practice of my art, gaining the respect of all men for all time. However, should I transgress this Oath and violate it, may the opposite be my fate.

(q) *Estimates of the Prevalence of Problematic Drug Use&Needs Assessment Guidance for Adults*

In her Report, Louise Man outlines a useful description of the Problematic Drug User (PDU) and advises the estimation of their number in a community and the care services which should be required to provide for them. To paraphrase parts of the Report:

The typical PDU is male aged 20-30 and is dependent upon opiates +/- crack (+/- other drugs at the same time). His primary problem is not usually powder cocaine, amphetamine, ecstasy, hallucinogens or cannabis.

He has experienced disadvantage from an early age and mental or physical trauma in childhood. He lacks education, may have been bullied at school and has few educational attainments or skills. He may have started on cannabis at school and moved onto other drugs later.

There are problems with housing and he might be homeless. He may have mental and physical problems, and there are high rates of hepatitis, and HIV/AIDS all of which affect his ability to carry out daily tasks and to work. He feels stigmatised and a social outcast.

PDU's have barriers to work even when the drug addiction is under control; the impaired health, lack of skills, social disadvantage and stigma are all against him. As he has most probably been involved in petty crime, he will have acquired a criminal record and employers are unwilling to take on someone with a CR. About 1% of the adult population are classed as PDU, about 7% of all benefit recipients.

Man L (2007) Report for the Department of Works and Pensions July 2007
www.nta.nhs.uk/uploads/guidance_using_pdu_estimates.pdf

Note :The PDU (Problematic Drug User) is now called a 'High-Risk Drug User'(HRDU).
p 21

This key indicator collects data on the prevalence and incidence of high-risk drug use (HRDU) at national and local level. It was formerly called problem drug use(PDU).

The indicator which has recently been revised mainly due to the changing drug situation, focuses on 'recurrent drug use that is causing actual harms (negative consequences) to the person (including dependence, but also other health, psychological or social problems), or is placing the person at a high probability/risk of suffering such harms'

From EMCDDA Information on high-risk drug use
<http://www.emcdda.europa.eu/activities/hrdu>

Chapter 3 Prohibition

(r) *Junk policy. It's the illegality of heroin which leads to the*

deaths among users, says Johann Hari. pp10-12 The Spectator 9 May 2015 A shortened paraphrase of the article.

When Dr John Marks joined the GPs in the Wirral in 1982 he was the 'new boy' there and was allocated all the drug addicts who attended the surgery every Thursday for repeat prescriptions of heroin. He tried to shut the clinic down, to wean them off it, but that only resulted in arguments and so he gave way. Moreover he found to his surprise that the addicts were not what he had expected: near criminals, prostitutes and unemployed people with HIV, abscesses, hepatitis and a high death rate. That is how new patients looked before they were treated in his surgery. The 'old' addicts on prescription heroin looked like the nurses or receptionist or like Dr Marks himself. As a group you couldn't tell.

Faced with this evidence Dr Marks began to believe that many of the 'harms of drugs are to do with the laws around them not the drugs themselves.' In the surgery itself they used to refer the others with infections, abscesses and amputations the 'drug-war wounded.' He began to wonder: if prescription is so successful, why don't we do it more? Gradually his programme expanded from a dozen patients to four hundred.

The police were the first to notice that in the practice area there was a 93% fall in theft and burglary. The local police Inspector Michael Lofts said; "... since the clinic opened, the street dealers have abandoned the streets of Warrington and Widnes." And then something happened which no-one had expected the number of heroin addicts in the area

started to fall. Dr Marks published his findings in the Proceedings of the Royal College of Physicians of Edinburgh. The tabloids got hold of the story; diplomatic pressure from the US government, which was intent to enforce prohibition, forced the UK government to close the clinic down. During the thirteen years (1982-1995) the drug clinic was run by Dr Marks there was not a single drug-related death. After closure 20 patients had died within the first six months and another 41 within the ensuing 2 years. Dr Marks was blacklisted by the medical profession and emigrated to New Zealand.

My addition: it was in 1990 that the Swiss heard of Dr Marks' and his method of treatment of heroin addicts and Professor Uchterhagen, of Zurich, initiated his HAT (heroin assisted therapy) scheme which has been one of the success stories of Swiss Drug Policy.

(s) *The effect of gaining a criminal record : Stuart's Story,*
quoted from Release

...My personal experience happened nine years ago; I was a Registered Nurse, engaged to an incredibly beautiful woman, both inside and out, with our own home and progressing nicely in my chosen career which I loved.

The nightmare started when I was stopped, whilst driving, by a police car outside Manchester. This was ten minutes after I'd been to a house to buy ten ecstasy pills for the forthcoming weekend. Obviously they knew where I'd been for they asked me whether I had any prohibited substances in the car.

Well, to cut a long story short, I had to go to court, despite my solicitor begging for me to be given a caution for a first offence, so I received a fine and a suspended sentence. But that was only the beginning of the nightmare.

I lost my job and was unable to work as a nurse, and became unemployed. I couldn't find alternative employment due to the nature of the offence and how recent it was. Also there was the huge stigma of a Registered Nurse using drugs. As a result I couldn't pay my mortgage, my relationship broke down and for the past five years (whilst my conviction was becoming spent) I had to take odd jobs in bars, taxi driving and working on building sites. I now work in a steel works, and haven't returned to nursing.

By anyone's idea of justice, I think I've been thoroughly punished. But what did I do that was so wrong to have my life destroyed?"

From Release 2013 *Drugs-it's time for better laws* p2

www.release.org.uk/blog/drug-its-time-for-better-laws accessed 100914

(t) *Labelling Theory.*

Howard Becker,(1963) put forward the proposition that 'Labelling (a person)' is associated with the concepts of self-fulfilling prophecy and stereotyping. Labelling theory holds that deviance is not inherent to an act, but instead focuses on the tendency of majorities to negatively label minorities or those seen as deviant from standard cultural norms.

Thus if a drug offender, having been tried and sentenced under the criminal law gains a 'criminal record', he is not only debarred from a large range of future employments and activities, but he is inclined *to live up to his record/reputation*. Thus his psychology leads him to repeat his misdemeanours, precisely contrary to the object of the law which is supposed to encourage a person to 'go straight' and reintegrate into society.

Wikipedia *Labelling theory*

en.wikipedia.org/wiki/Labelling_theory

I am grateful to Gordon Low (see acknowledgements) for drawing my attention to this matter. He, being a Probation Officer, pointed out to me that the clients he has in his care often suffer significantly from this stigma long after they have rehabilitated themselves.

(u) Britain's illegal drugs trade worth £8bn a year

By Nigel Morris , Home Affairs Correspondent Independent Newspaper Wednesday 21 November 2007 Britain's illegal drugs trade is worth up to £8bn a year, a Home Office report has revealed. Drugs are smuggled into the country by 300 major importers and distributed by 3,000 gangs, the research showed.

The contraband is then sold on to users by 70,000 dealers, some with hundreds of customers. The dealers earn an average of £100,000 a year and their annual turnover is estimated at between £7bn and £8bn equivalent to more than 40 per cent of Britain's alcohol sales and one third of its tobacco sales.

The Home Office study was based on 220 interviews with convicted dealers. It discovered enormous mark-ups in the value of class-A drugs between their production abroad and sale.

Cocaine costs £325 per kilo to manufacture in South America. By the time it is sold in Britain, after being smuggled via the Caribbean, its value has risen to £51,650 per kilo. Afghani heroin costs about £450 per kilo to make but sells for £75,750.

Chapter 4 Legalisation and Decriminalisation

(v) *The Dutch Youth Culture of the 1960's*

When I was the Director of Public Health of the Gt Yarmouth and Waveney Health District in the 1990's one of the matters which came to my attention was that our district had the highest rate of teenage pregnancy and pregnancy termination in East Anglia. We then got a health care researcher, Karen Robinson, attached to my department to investigate this.

She found out that the teenagers, girls as well as boys, were well taught at school about sex and the avoidance of risks, but when it came to going to alcohol fuelled parties they forget what they knew they should do, with the expected outcomes. What should be done about that was clear to me; that is to protect them with such contraceptive measures so it wouldn't matter if they remembered to take care or not. We formed a working party to set about that; it was a difficult subject for the ideas of parents could not be overridden and we were still in the wake so to speak of the Gillick affair. We were beginning to make good progress but then the Health Authority was abolished (under the Government's economy measures of the time) and our activities ceased.

Karen, the research assistant, had however found out what they were doing in Holland, for there they had the lowest teenage pregnancy and lowest abortion rates in Europe, despite their sexual freedom, or promiscuity as some would describe it. And on that last point the Dutch had also the lowest divorce rate in Europe; one almost felt that the Dutch young adults having got the matter of sex 'out of the system', could settle down to the serious business of love and marriage.

What seemed to be happening in Holland was that the youngsters were taught the 'facts so life', as they were in England, and were just as forgetful when under the haze of alcohol; but there the Dutch girls had been put on contraceptive pills or long-acting subdermal contraception with their parents' consent long before the risks occurred. And so the risk and harm of unplanned teenage pregnancies were avoided until the youngsters had become older, wiser and mature enough to be able to think about what they were doing.

Reference Annual Report of the Director of Public Health for 1991-92 page 44 et seq

(w) *Remarks of Mrs May, Home Secretary*

.House of Commons Home Affairs Select Committee.July 2012.Para 256 page 101

‘When discussing the Portuguese system of depenalisation, The Home Secretary Mrs Theresa May remarked that

“I think it is rather-if I can put it like this-perhaps less clear than it is sometimes claimed to be. I know that it is constantly being adduced as an example of where decriminalisation and a different approach can have an impact on drugs-I was just looking for some figures that I know were in my briefing .However, I am not convinced that that has actually had the impact that everybody feels it has had.”

‘The Home Secretary was asked if she had discussed the Portuguese system with her counterparts there as, following a recent visit as part of this inquiry, we had been surprised by the high-levels of cross party support for the system. She replied:

“ I personally have not had conversations with individuals in Portugal... Of course we have looked at what has happened in Portugal and elsewhere, but the facts, as I say, give a slightly different picture that the one that is sometimes portrayed...I suspect we may come from a fundamentally different point of view in relation to drugs. I have some very clear views that we should be doing everything we can to deal with drugs, having seen some of the impacts of drugs on individuals and on families.” ’

www.Publication.parliament.uk > ... > Home Affairs. Breaking the cycle

(x) Portugal’s legal possession quantities

25 g Cannabis (herb)	2 g Cocaine (Hydrochloride)	0.1g PCP
5g Hashish	0.3g Cocaine(Benzlecogonine)	
2.5 g Cannabis Oil	1g Heroin	
0.5 g Pure THC	1g Methadone	
500ug LSD	2g Morphine	
1 g MDMA (Ecstasy)	1g Amphetamine	

from Wikipedia *Drug Policy of Portugal*

en.wikipedia.org/wiki/Drug_policy_of_Portugal acc 26092014

(y) Effects of Cannabis

Cannabis causes few undesirable social consequences, and any such consequences are mainly prevalent among heavy users It is also pointed out that there is no proof that such consequences are directly related to the use of cannabis rather than the social reaction to its consumption. The effect of cannabis does not depend only on its composition, dosage or mode of consumption but also on the user’s state of mind, expectations and the atmosphere at the time.

Acute toxicity of cannabis is generally considered to be rare. A psychotic state may appear after use of high doses of cannabis. Reassurance is often enough to calm the person down. The use of cannabis may lead to psychological dependence. The tendency towards physical dependence is, however, very low.

The ability to drive a motor vehicle is impaired for two to four hours (maximum eight hours) after using cannabis. Users often over-estimate the effect of cannabis on their ability to drive a motor vehicle and therefore concentrate more intensely and drive more slowly. It was also proven that in 80% of accidents where THC was found in the plasma of the responsible parties, their alcohol level was also positive.

The “amotivational” syndrome, which entails personality change, neglect of one’s appearance and general disinterest displayed by habitual cannabis users, was never confirmed.

It is advisable to abstain from cannabis, tobacco and alcohol use during pregnancy.

The human immune system is relatively resistant to the immunosuppressive effects of cannabinoids and research results support the therapeutic use of delta-9-THC in patients whose immune system has already been weakened by other diseases such as AIDS, or cancer.

In 2008 the Swiss Federal Office of Public Health brought out a new report on the social and health problems linked to cannabis use. It concluded that politically driven claims of extreme danger were unfounded. Occasional cannabis use appeared to give rise to no problems. A survey of 5,000 students at the University of Lausanne who were occasional users obtained better grades than those who abstained.

(1) Chantal C (2012) *Switzerland's Drug Policy*

www.parl.gc.ca/Content/SEN/Committee/371/ille/library/collin1-e.htm

(2) Swiss Federal Office of Public Health (2008) (*Eidgenössische Kommission für Drogenfragen*) (*Lagebeurteilung und Empfehlungen der Eidgenössischen Kommission für Drogenfragen*)

(3) Savory et al *The Swiss Four Pillars Policy; An Evolution from Local Experimentation to Federal Law*. Beckley Foundation Drug Policy Programmes :Briefing Paper Eighteen

(4) Wollaston S in the debate in the House of Commons on 30th October 2014 spoke out that people should not be

misled, long term use of cannabis can give rise to psychoses especially if there is a family history of schizophrenia and quoted from her own experience of the risk of cannabis precipitating psychotic illnesses. She mentioned that if a cannabis smoker has 1st degree relations with schizophrenia there is a 10-20% risk of doubling the chance of getting the illness themselves.

(5) Stevens A *Drugs*, (2011) *ibid* pp79-83

Note: The 'ordinary' cannabis rarely causes much trouble; cannabis fortified either by selective growing or by the addition of chemical tetrahydrocannabinol, so called 'skunk' is reported to exacerbate significantly the psychosis inducing risk. It is banned in Dutch coffee-shops.

Source Adams S (2015) *Scientists show cannabis triples psychosis risk*. Mail on Sunday 15 Feb 2015

(z) Drug Injecting Centre.

WHO's United Nations Office for Drugs and Crime recommend a Drug Injecting Centre to provide the following;

- 1 Needle and syringe exchange programmes
2. Opioid Substitution Therapy
3. HIV Counselling and Testing
4. Anti-Retroviral Therapy
5. Sexually Transmitted Infection Prevention.
6. Condom programme and provision for Injecting Drug User and Partner.
7. Targeted Information, Education, and Communication for Users and sexual partners.
8. Hepatitis diagnosis, treatment and vaccination for Hepatitis A, B and C
9. Tuberculosis prevention, diagnosis and treatment.

It goes on to state: '*The interventions in the comprehensive package are supported by a wealth of scientific evidence*' and refers to WHO/UNODC Evidence for Action series and policy briefs available at <http://www.who.int/hiv/pub/idu/en/>

(aa) The citizens of Zurich take action

At that time (*early 1980's*) three quarters of bag snatching and one third of the burglaries were motivated by the need to find money to pay for drugs. The local citizens demanded action and GPs initiated Methadone substitution therapy which changed all that. A 90% reduction of crimes against property of resulted, 85% decrease in shop-lifting and 76% fall in the sale of cannabis.

When heroin substitution therapy was introduced to those not responding to Methadone, there was a 100% fall in burglary and 83% fall in the sale of hard drugs together with a 50% reduction in the prison sentences handed out.

Ref Savoury J-F, Hallam C & Bewley-Taylor D (...) *The Swiss Four Pillars Policy: An evolution from local experimentation to Federal Law* The Beckley Foundation Drug Policy Programme http://www.beckleyfoundation.org/pdf/BriefingPaper_18.pdf.

(bb) Population and Demographic Comparisons

	Portugal	Netherlands	Germany	Czech Rep	Switzerland	UK	EU
Population/million	10.5	16.8	80.5	10.5	7.5 (2)	63.5	
15-24 (%)	10.7	12.2	10.9	11.1	11.4(5)	12.9	
25-49 (%)	35.4	33.5	31.4	37.3)	34.2	
50-64 (%)	19.8	20.3	21.1	20.0)59.9(5)	18.1	
GDP	76	128	123	81	160(2)	106	100
% on social protection	26.5	32.3	29.4	20.4	19.4(2)	27.3	29
Unemployment as %	16.5	6.7	5.3	7.0	3.0(3)	7.5	10.8
Under 25 as %	37.7	11.0	7.9	18.9	7.5(3)	20.5	23.4
Poverty as %	17.9	10.1	17.0	9.6	13.9(4)	16.2	17.0

Sources EMCDDA statistics

OECD Statistics www.stats.oecd.org

Trading Economics www.oecd.org/employment/database

European Statistics(2012) People at risk of poverty or social exclusion Epp
at.ec.europa.eu/statistics.../People_at_risk

Index Mundi

(cc) Impact Analysis Project of New Drugs Legislation(PAD Report)

Initiated by the Government of the Czech Republic.

In the report Zabransky noted that the costs incurred during the year of audit, when drug possession was a criminal matter, came to CZK37million. Money which was ‘wasted’ and could have been spent better. This sum was arrived at by implementing section 187a of the Czech Criminal Code, so per offender the costs were

Police activities	CZK	107,616
Prosecution costs	CZK	9,483
Court expenses	CZK	12,707
Prison	CZK	18,381 av.time spent in prison was 9 months
Loss of productivity	CZK	13,072
total	CZK	161,260 p.person x number of prisoners
total cost during the years of the survey=CZK 37million		

The authors noted

‘...the implementation of penalisation of possession of illegal drugs for personal use was economically disadvantageous and incurred costs...that could have been used in a different manner

‘.. It was proved that there was a zero deterrent effect on the population of problem users. Members of the subject population, of the police, therapist and experts from helping institutions share this opinion’.

Source: Zabransky T, Mravcik V, Gajdosikova H, & Miovska M, (2001) *Impact Analysis Project of New Drugs Legislation, Final Report*, Secretariat of the National Drug Commission, Office of the Czech Government October 2001

(dd) Pervitin (Methylamphetamine) in the Czech Republic

Pervitin has been a commonly used drug of abuse in the Czech Republic for many years and is unique in this in the European Union. There are approximately 20,000 problem users in the country, of which 80-90% are injecting users, and about 60% of those are in medical treatment. They are not treated differentially from heroin injecting users, and harm reduction has the same objective, namely avoidance of infection with

HIV, HCV or HBV. Due to the extremely extensive needle exchange cover in the country, the number of persons becoming infected is well below 1% annually. There is no specific substitution treatment as there is with heroin. Gelatin capsules are provided to encourage users not to inject.

Toxic psychoses may develop especially in withdrawal. There are 10-20 fatal overdoses a year, one third of all fatal drug related overdoses.

Pervitin is obtained from home 'cooking' usually being derived from over the counter pharmaceuticals. Illegal manufacturing seized by the police rose from 188 in 2003 to 434 in 2008. It became popular during the communist era because it was impossible to smuggle the usual illegal drugs into the country.

Source mainly from The Czech Republic Drug Situation Annual Report 2008

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